

Annex: MUCH MORE THAN WORDS

Spoken communication and
patient safety in the NHS

Report of the Patient Safety Initiative Group

NHS Improvement

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CONTENTS

PLAIN ENGLISH SUMMARY	I
EXECUTIVE SUMMARY	II
BACKGROUND AND SCOPE	1
HISTORY AND CONTEXT OF THIS REPORT	1
TERMS OF REFERENCE	1
THE IMPORTANCE OF SPOKEN COMMUNICATION IN CONTEMPORARY HEALTH CARE	2
TOOLS AND CHECKLISTS TO IMPROVE SPOKEN COMMUNICATION	3
METHODS AND DATA SOURCES	4
OBJECTIVES AND WORKING METHODS	4
DATA SOURCES 1: PRE-EXISTING REPORTS AND ACCOUNTS OF SPOKEN COMMUNICATION	4
DATA SOURCES 2: CONSULTATIONS WITH NHS PATIENTS AND STAFF	5
FINDINGS: SIX CHALLENGES WITH SPOKEN COMMUNICATION IN HEALTHCARE SETTINGS.....	6
CHALLENGE 1: THE COMMUNICATION ENVIRONMENT	6
CHALLENGE 2: INFORMATION EXCHANGE.....	7
CHALLENGE 3: ATTITUDE AND LISTENING.....	9
CHALLENGE 4: ALIGNING AND RESPONDING	12
CHALLENGE 5: CREATING THE PRECONDITIONS FOR EFFECTIVE COMMUNICATION WITHIN A TEAM.....	14
CHALLENGE 6: COMMUNICATING WITH SPECIFIC GROUPS	16
DISCUSSION	22
SUMMARY OF KEY FINDINGS.....	22
CHALLENGES ARE COMPLEX; SOLUTIONS WILL NOT BE SIMPLE	23
A CALL FOR A NEW PARADIGM IN SPOKEN COMMUNICATION	23
CONCLUSION	25
ACKNOWLEDGEMENTS	26
BIBLIOGRAPHY.....	27
APPENDIX: MEMBERSHIP OF PATIENT SAFETY INITIATIVE GROUP.....	29

Plain English summary

This report has been produced by an interdisciplinary patient safety initiative group sponsored by NHS Improvement. We sought to understand (with a view to improving) how spoken communication (especially between two people) may contribute to patient safety in NHS care. We reviewed hundreds of examples of spoken communication – between NHS staff, and between staff and patients – from a range of sources including official documents (e.g. National Reporting and Learning System incident reports, Clinical Outcomes Reviews), publicly available data (e.g. patient feedback websites), research studies (especially qualitative studies of real encounters) and direct consultation with NHS patients and staff (focus groups and workshops).

We sought to learn from examples of good communication as well as from incidents where communication could have been better. Drawing on both, we have identified six key themes:

- a. THE COMMUNICATION ENVIRONMENT (which should ideally provide adequate time, privacy and comfort);
- b. INFORMATION EXCHANGE (adequate and correct information must be passed between the right people at the right time);
- c. ATTITUDE AND LISTENING (rudeness and ignoring people may have safety-critical consequences);
- d. ALIGNING AND RESPONDING (conversations go back and forth, and each speaker must continually check understanding and take account of how the other is reacting);
- e. CREATING THE PRECONDITIONS FOR EFFECTIVE COMMUNICATION WITHIN A TEAM (everyone must feel confident to speak up); and
- f. COMMUNICATING WITH SPECIFIC GROUPS (additional care is needed, for example, for children and those with limited English, impaired hearing, limited capacity to understand or a mental health condition).

Our findings strongly support the conclusion that spoken communication should be thought of not merely as the transmission of information but as **context-dependent social interaction**, influenced by roles, expectations and hierarchies and by the wider pressures and distractions of a busy care environment. Examples of good communication show how safe talk takes account of all these social conditions, is respectful of others and flexible. Tools intended to improve spoken communication have a place but may impose an artificial structure on natural speech, with adverse consequences.

Our extensive search of multiple data sources turned up rare examples of extremely poor practice, sometimes from individuals who consistently failed to meet basic standards of clear, polite and appropriate communication. However, most examples of poor spoken communication consisted of avoidable mishaps (or poor choice of words) that any of us, on a bad day, might make – and which could potentially have safety-critical consequences.

Notwithstanding the many examples of good practice we uncovered, there is much scope for improvement. We plan to work with NHS Improvement on a further piece of work to develop recommendations and interventions. At this stage, we caution against jumping to simplistic or formulaic solutions. Rather, we propose that the first step towards developing systematic approaches to improving spoken communication across the NHS is to appreciate the richness, complexity and social embeddedness of the words we exchange.



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Chair, Patient Safety Initiative Group

Executive summary

1. This document reports the findings of an interdisciplinary group, sponsored by NHS Improvement, whose official title was 'Improving Safety Critical Communication Patient Safety Initiative Group'. It was established in September 2017 with the aim of informing a programme of work to improve patient safety.
2. The scope of this first phase of work was to inform understanding of the nature of good spoken communication between two (or sometimes more) people, and to explore the causes of poor spoken communication between staff and patients, or among staff, as it impacts on patient safety. Future work will identify and develop potential interventions and suggest how these may be implemented across the NHS.
3. Membership of the Patient Safety Initiative Group is listed in the Appendix (page 25). The group had representation from policymakers (including some national patient safety leads) practising health professionals (including Fellows of several Royal Colleges), NHS managers, academics (linguists, social scientists, psychologists) and patient representatives.
4. Examples of both good practice (which may have saved lives) and poor practice (which may have placed patients at risk) in spoken communication were obtained from various data sources:
 - a. Official sources, including National Reporting and Learning System incident reports, Patient Advice and Liaison Service reports, Clinical Outcomes Review Programme reports (previously known as Confidential Inquiries) and reports from Royal Colleges;
 - b. Grey literature reports and examples e.g. from Patient Safety Collaboratives, Royal Colleges, professional indemnity bodies, Health Foundation, 'best practice' websites;
 - c. Patient experience resources (patient and public involvement representatives, online patient communities, patient feedback websites, patient charities);
 - d. Selected academic research (especially qualitative studies of real-world interactions);
 - e. Findings from four patient focus groups (people with learning difficulties, mental health service users, limited English speakers) and two workshops (comprising 80 participants from NHS clinical and non-clinical staff and patient advocacy groups).
 - f. Other sources known to working group members (e.g. own clinical experience).
5. Some examples of safety-critical communication failures appeared to be associated with individuals who consistently failed to communicate clearly, effectively or politely. However, we also found many examples of the kind of communication failure that could happen to almost anyone where the circumstances are challenging, the communication setting is less than ideal or the person doing the communicating is having a bad day.
6. We identified six key areas in which there may be challenges to spoken communication:
 - a. **THE COMMUNICATION ENVIRONMENT.** The ideal environment for spoken communication provides adequate time, privacy and comfort. Clinicians and patients are relaxed and do not feel under pressure, and there are no distractions or interruptions.
 - b. **INFORMATION EXCHANGE.** Good spoken communication occurs when accurate and appropriate information is exchanged between the right people at the right time and all parties convey that they have understood.
 - c. **ATTITUDE AND LISTENING.** Effective communication is associated with: respect, commitment, positive regard, empathy, trust, receptivity, honesty and an ongoing and

collaborative focus on care. Listening occurs most readily in situations where there is adequate time, privacy and comfort, and when clinicians are committed to the patient's care and emotionally attuned to the needs of patients, carers and staff.

- d. **ALIGNING AND RESPONDING.** Alignment means that both speakers can negotiate shared assumptions about what is appropriate behaviour, what information needs to be exchanged and how, and what particular words and phrases mean. For effective communication, both parties need to recognise and adapt to each other's spoken and unspoken needs and expectations. This interpersonal adaptation is not a one-off 'check' but an ongoing process that enables the conversation to flow and evolve.
 - e. **CREATING THE PRECONDITIONS FOR EFFECTIVE COMMUNICATION WITHIN A TEAM.** Effective communication in a team occurs when there is an open, trusting and mutually respectful ethos as well as psychological safety (i.e. anyone in the team, however junior, feels confident to raise concerns or point out problems). If these conditions are met, safety concerns are more likely to be surfaced and dealt with.
 - f. **COMMUNICATING WITH SPECIFIC GROUPS.** Additional care needs to be taken when communicating with groups such as children and young people, people with problems understanding spoken English (e.g. limited English speakers, people with hearing impairment, learning difficulties or cognitive impairment) and people who are distressed or have mental health conditions. Extra time, along with a flexible, personalised, context-sensitive and holistic approach is needed: one size does not fit all.
7. Our findings strongly support the conclusion that spoken communication should be thought of not merely as the transmission of information but as context-dependent social interaction that unfolds dynamically. It is influenced by roles, expectations and hierarchies and by the pressures and distractions of a busy care environment. Tools and checklists intended to improve it (such as SBAR: situation-background-assessment-recommendation) may help in specific circumstances but imposing an artificial structure on spoken communication may have adverse consequences.
 8. The examples of communication we reviewed included some problems (such as excessive use of jargon and acronyms) for which there may be relatively straightforward solutions. But we also identified problems (communication expressing dismissive attitudes, lack of psychological safety in multidisciplinary teams, extended misunderstandings and 'tribalism' among professional groups) that are likely to have long histories and multiple underlying causes; such problems are unlikely to be amenable to rapid fixes or standardised solutions.
 9. It is also true that in the millions of encounters involving spoken communication that occur in the NHS every day, a combination of human initiative, compassion and commitment can and often do allow staff to mitigate the time pressures, practical constraints and conflicting demands of a busy and fast-moving care environment.
 10. Because of the complexity and social embeddedness of spoken communication, there will be few mechanistic or universal solutions (in other words, good spoken communication cannot be 'scripted'). Rather, we propose that any further work to develop interventions will take note of three linked tensions that have emerged in the work undertaken to date:
 - a. The tension between the ideal communication situation summarised in paragraph 6a above and the *actual* situations in which spoken communication happens in the NHS;
 - b. The tension between a narrow definition of good communication (exchange of precise, accurate and relevant information) and a broader definition (a social, emotional and cultural act requiring situational awareness, emotional engagement and reflection); and

- c. The tension between a structured and standardised approach to improving communication (supported by tools, technologies and checklists) and an approach that celebrates and supports the adaptiveness and intuition of individuals (whose responses to particular local challenges may rightly be unique).
11. Improving spoken communication across the NHS requires action from many stakeholders to establish a new paradigm that addresses not only the structure and format of the message but also how to attend adaptively to an unfolding interpersonal interaction in a way that takes account of social nuances and organisational context.
 12. NHS Improvement is now considering a second phase of work which will involve working with NHS staff (both clinical and non – clinical), leaders of NHS organisations, people who train clinicians and other NHS staff, national bodies and patients and carers. The aim will be to develop specific interventions (where appropriate) as well as identifying existing interventions that could be implemented more widely, with the aim of improving the safety of spoken communication in the NHS in England. We should not pre-judge this work but we would suggest the second phase of work consider how the following groups can be supported:
 - a. *NHS staff* (both clinical and non-clinical) have a responsibility to know what good practice in spoken communication (broadly defined) looks like and strive to achieve this, both with other NHS staff and across the full diversity of patients and carers who use the NHS;
 - b. *People who train clinicians and other NHS staff* have a responsibility to select, train and nurture good communicators using the best methods and most up-to-date evidence. In particular, they must go beyond didactic and scripted approaches to ensure that learners are adept at communicating effectively in a range of complex social situations;
 - c. *Licensing and professional bodies and employers* have a responsibility to ensure that consistently poor communicators are identified and supported to improve not merely what they say but how and to whom they say it – and to listen and attend to others. Rarely, poor spoken communication may precipitate a fitness to practice review.
 - d. *Leaders of NHS organisations* have a responsibility to ensure that the environment in which care is delivered is conducive to effective spoken communication (e.g. ensure privacy; reduce noise and interruptions; provide access to interpreters and advocates; model psychological safety; support and reward good practice). They must also ensure that staff are appropriately trained and drive cultural changes to support an adaptive and reflexive approach to improving spoken communication;
 - e. *NHS patients and their carers* have a right to clear, appropriate and respectful spoken communication; to feel safe to speak up; and, when needed, to receive support and help in communicating. They should also be given the opportunity, insofar as they are able, to convey their concerns, expectations and information needs and asked whether they have understood what has been said to them;
 - f. *Advocates for vulnerable and special-needs groups* have a mandate (and a responsibility) to convey the perspective and needs of particular individuals and groups. They, and the groups they represent, have a right to be heard and to help shape NHS services to meet an increasingly diverse set of needs in an ageing and multi-cultural society;
 - g. Finally, *national policymakers* have a responsibility to support development of the new paradigm for communication by developing policy, guidelines, training and resources and making these widely accessible, and to identify and use system-level levers that will support the necessary changes across the NHS.

Background and scope

History and context of this report

Spoken communication is an under-used, under-appreciated and under-studied resource for ensuring that clinical care is safe and effective. Specific spoken words (such as the name, dose or route of administration of a drug) more general aspects of spoken communication (such as conveying concern that a patient is deteriorating) can be safety-critical in many clinical situations.

This work was initiated by the Patient Safety Team in NHS Improvement, who were keen to address patient safety concerns too complex to be managed solely through patient safety alerts or dissemination of information via existing clinical networks, but not requiring whole-system policy approaches. The team sought to explore how to make meaningful progress on this issue and improve safety in a timely way within available resources by (for example) working in partnership with front line staff, professional organisations, patient representatives and other experts in safety.

NHS Improvement's Patient Safety Team drafted an operating model comprising an initial prioritisation process, followed by three sequential stages: understanding the issue; developing potential interventions; and implementing selected interventions. Each stage depends on the previous stage and the decision to move to the next stage rests with the Patient Safety Management Team, depending on the success of the preceding stage and the likelihood of successfully completing the next stage. Improving spoken communication was identified as the first topic to test this model with. The Improving Safety Critical Communication Patient Safety Initiative Group was asked to address the first stage of the process: understanding the issue. This report sets out the findings of that stage.

Terms of reference

The following terms of reference were refined and agreed at the first meeting of the group.

This project sought to explore the process of **spoken** communication (especially between two people) between staff and patients, and among staff (both within and between teams), in situations relevant to patient safety in all areas of NHS care. Our brief was to consider examples of good practice (effective communication that was followed by appropriate action) as well as those where patient safety was jeopardised – including communication that

- was inadequate (e.g. incomplete, careless);
- occurred between the wrong people, at the wrong time or in the wrong place;
- was misunderstood or misinterpreted; or
- did not occur at all (e.g. because someone did not speak up).

Situations where effective spoken communication occurred but was not followed by appropriate action were considered to be beyond the scope of this project.

The primary audience for this report was the Patient Safety Team at NHS Improvement. Additional audiences include others who are interested in patient safety, such as:

- NHS staff – both clinical and non-clinical;
- People who train, oversee and licence NHS clinical staff;
- People who create and support the environment in which staff work;
- Patients and their advocates;
- Policymakers responsible for overseeing an effective and safe healthcare system.

The importance of spoken communication in contemporary health care

Most previous research and policy analysis on communication and patient safety has focused on written communication, but safe healthcare also depends heavily on the spoken word. Good spoken communication is partly about passing on clear and accurate information. But it is also about expressing uncertainty, reading or 'sensing' situations, assessing others' understanding of decisions and their appreciation of responsibilities, and remembering to follow up on issues and concerns.

Framed like this, we can say that spoken communication encompasses four key domains:

- *what* we say: for example, is it accurate, precise, succinct, clear and appropriate?;
- *how* we say it: for example, tone, body language, judgmental or blame-free emphasis;
- *who* we say it to, taking account of questions such as: what is my relationship with this person?; what does the person already know and understand?; are they expert or novice?; to what extent are they likely to be aware of safety-critical issues?; and to what extent are they likely to be preoccupied, worried, or in a hurry?; and
- the *context* in which it is said, asking such things as: is this the right place and time to say things?; should we whisper, or raise our voice?; do role expectations or power relations create barriers to communication between different professions or social groups?; should we communicate what we want to say with other people as well as this person, or say it more than once?; should we, as well as speaking, write something down for others elsewhere or people arriving later?

Often, we address these questions intuitively. And because we usually take spoken communication for granted, we may be unaware when we are communicating inappropriately and ineffectively. Do we, for example, take on board the blank look from the patient whose grasp of spoken English is very different from our own? Do we notice the student nurse who would like to point out a problem but isn't sure she is allowed to speak up in the circumstances?

Because speaking often comes as naturally as breathing, we may need to consciously reflect not just on *what* we are saying and *to whom*, but also on *how*, *why* and *in what circumstances* we are saying it. Sometimes, this reflection is prompted by a significant event – something that is (at best) awkward or embarrassing and (at worst) linked to error or harm. Indeed, communication going awry is a critical part of experience and learning; it may highlight for us that we need to pay more attention to how we communicate, and to *how we are with other people*. The initial conversation after an error or harm with the patient or their family has been shown to create the foundations for the relationship beyond – sometimes (if done badly) with dire consequences.

Spoken communication is increasingly important as health care becomes more complex. Such things as multi-morbidity, an ageing population, migration, technological change, rapid turnover of staff (and structural changes such as the loss of 'the firm') have reduced the extent to which staff know and trust each other. Yet mounting knowledge and information, and growing bureaucratic, financial and regulatory pressures can all (in different ways) make spoken communication more tricky. With so many interacting influences on illness and its management, patient care is often characterised by uncertainty, and this usually needs to be conveyed to the patient (who may expect a clear answer one way or the other). More and more, clinicians, patients, families and administrative staff need to communicate in an ongoing way about what is best to do next. In other words, care decisions need to be crafted in the here-and-now from people's circumstances, knowledge, wishes and preferences. Such responses and decisions require delicate, sensitive and flexible communication.

For all these reasons, we should think of spoken communication not as something that should be tightly prescribed and standardised but as a complex and dynamic performance between people who

care (and people who are being cared for). The complexity and subtlety of spoken interactions become less visible when communication is rendered in the form of ‘say-this-now’ scripts that are embedded in tools and checklists (see examples in next section). Scripts provide basic guidance and essential safeguards, but communicating safely and effectively depends on considerably more than following scripts. Good communication necessitates careful attention to how we conduct ourselves towards one another, and how we reflect on the responses we receive. Such attention and reflection are now the mainstays of learning, respect and safety in any contemporary healthcare organisation.

Tools and checklists to improve spoken communication

The use of communication support tools in hospital and emergency settings has become widespread (Royal College of Physicians 2017). Such tools are sometimes regarded as *the* way to ensure good practice when communicating through speech in a healthcare setting (either face to face or on the phone). Importantly, all tools require expertise, skill and common sense to use to their best effect. They do not do the work of communication *for* staff. Below is a non-exhaustive list of such tools.

Team brief/debrief is a short session at the start of a shift or clinical activity in which the team comes together to discuss objectives, outcomes, roles, responsibilities and safety issues. Effective team briefs are linked to better patient safety outcomes. It typically includes a structured set of questions such as: Who is on the team? and Are roles and responsibilities understood? Debriefs allow the team to come together after a shift, procedure or difficult situation to reflect on what went well, what went wrong and how things can be improved. *Huddles (or safety huddles)* are used frequently across the NHS to bring people together either at a planned time or spontaneously to talk about safety issues.

Structured communication tools include *SBAR[R]* – Situation (what is going on with the patient?); Background (what is the clinical background or context?); Assessment (what do I think the problem is?); Recommendation (what help do I need? what should we do to correct the problem?) and [asking the other person to] Respond – designed for exchanging essential information clearly and assertively in emergency situations; the *Surgical Safety Checklist* (a written list, intended as a way to help people improve the way they spoke to each other and to get to know each other before doing a high-risk procedure); and *handover tools* to support a structured approach to handing over between shifts.

Call-out is a technique used to communicate critical information in an emergency. The clinician calls out questions and commands, ensuring that all team members are simultaneously informed of updates and can anticipate the next steps. It can lead to more accurate documentation. During the call-out the clinician should direct information to a specific individual. *Check-back* is where the communicator seeks confirmation that information has been received and understood. The ‘sender’ initiates a message which the ‘receiver’ accepts and confirms; the sender then verifies the message.

Many tools seek to structure or ‘script’ spoken communication. Students and early-career clinicians may find them helpful for organising their thoughts and structuring what they say – and such tools may provide a socially accepted way of overcoming power imbalances (e.g. enabling a nurse to challenge a doctor, or a junior a senior, more easily). However, more experienced clinicians typically expect more versatile, responsive and context-sensitive communication from their colleagues; they may find structured tools awkward and even counterproductive because they interfere with the flow of natural conversation (Iedema et al 2009, Dekker 2017).

In sum, whilst SBAR, briefing/debriefing, call-out, check-back and similar tools have a place in supporting spoken communication, especially in emergency situations, they are not a panacea. They were not designed to cover every spoken communication situation and featured very rarely in the examples we reviewed (both positive and negative).

Methods and data sources

Objectives and working methods

Our objectives as originally agreed in our terms of reference were to:

1. Convene a cross-sector group of experts including academic, clinical, managerial, policy, and ‘by experience’ (patients and carers) to address spoken communication in patient safety.
2. Identify, collect and analyse a wide range of data sources relating to patient safety incidents, focusing on spoken communication, including official incident reports and confidential inquiries, patient complaints, existing repositories (e.g. searchable public-access databases), new surveys or focus groups of patients and staff, academic and grey literature.
3. Summarise and synthesise key themes from these data sources.
4. Refine this synthesis through consultation with a wide range of patient and professional stakeholders.
5. Include examples of good as well as poor practice in spoken communication.
6. Produce a short report with a lay and executive summary, whose primary audience is NHS Improvement Patient Safety Management Team but which will also be disseminated to NHS organisations and professional bodies, and placed in the public domain.

The members of the working group and their affiliations are listed in Appendix 1, page 25. The group met approximately monthly for nine months (mostly face to face but twice by webinar), and also communicated by email. Members worked between meetings to identify, access and summarise a range of data sources (listed below), convene focus groups and workshops, review data and articles, and contribute to drafting this report. Whilst the terms of reference emphasised spoken communication “between two people (or more when a carer was involved)”, our dataset revealed examples of spoken communication among teams involving more than two people; these were included on the grounds that they raised important additional themes relevant to patient safety.

The group pooled a large number of clinical communication examples and case studies. We analysed these data, classifying the examples according to the type of communication, what kind of problem or challenge it illustrated, and whether it was a positive, negative or mixed example. This yielded a detailed overarching framework that allowed us to classify examples of spoken communication into a broad spectrum of challenges and strategies.

A confidential draft of this report was sent to six peer reviewers representing NHS, academic and lay sectors (see Acknowledgements for details); the final version incorporates their feedback.

Data sources 1: pre-existing reports and accounts of spoken communication

In addition to our professional and lay experience working in the patient safety field, the Group drew on a wide range of written resources to gain examples of how spoken communication may contribute both positively and negatively to patient safety. These included:

Official sources

- National Reporting and Learning System reports (a national database held at NHS Improvement covering reports of deaths, severe harms and near-miss incidents) within England and Wales
- Complaints and other narratives from Patient Advice and Liaison Service and GP practices
- Coroners’ reports

- General Medical Council advice to doctors
- Clinical Outcomes Reviews (previously known as National Confidential Inquiries)

Grey literature reports and examples, such as

- Reports from think tanks and health service charities e.g. Health Foundation, Point of Care Foundation, Kings Fund
- Royal College of Paediatricians and Child Health reports of communication with children and young people
- Reports from professional indemnity bodies e.g. Medical Defence Union
- Reports from patient charities e.g. Patients Association, MIND, Mental Health Foundation
- Reports from patient and public involvement representatives
- 'Sign up to Safety' website (www.signuptosafety.org.uk)
- 'Best practice' websites for healthcare, especially Learning from Excellence (<https://learningfromexcellence.com>)

Patient experience resources, such as

- Examples collected by patient and public involvement representatives on this group
- Databases of patient experience e.g. Care Opinion (<https://www.careopinion.org.uk>), HealthWatch (<https://www.healthwatch.co.uk>)
- Patient charities e.g. Mencap
- Selected online communities (e.g. Facebook groups for particular conditions)

Selected academic literature, especially

- Syntheses of quantitative data (for example, Reader et al 2014).
- Qualitative studies of clinician-patient and clinician-clinician interactions
- Qualitative studies of patient accounts of their experience e.g. Healthtalk database (<http://www.healthtalk.org>),

Data sources 2: Consultations with NHS patients and staff

Four focus groups were held to capture the experience of patient groups who were under-represented in the sources detailed above. This included two focus groups (held in Leicester) involving 16 participants with limited English and 12 participants who had used NHS mental health services. An additional existing user group was consulted involving six service users with learning difficulties and one advocate.

Two half-day workshops were held (in London and Leeds), involving a total of around 80 NHS staff including doctors, nurses, pharmacists, allied professions, interpreting and advocacy staff, and managers. Patient advocacy organisations were also represented. In these workshops, participants worked in small groups to reflect on their own experiences of spoken communication and review a brief visual representation of the main themes emerging in our draft report. Outputs were summarised on flip chart paper, synthesised and used to refine and extend the final report.

Findings: Six challenges with spoken communication in healthcare settings

Our review of existing documentary sources and the focus groups and workshops we held identified an important theme: spoken communication is much more than the transmission of accurate information from a 'sender' to a 'receiver'. Rather, it is a context-dependent social act, influenced by roles, expectations and hierarchies and by the wider pressures and distractions of a busy care environment. In the sections below, we describe six key challenges to good spoken communication, along with positive examples of good practice as well as examples of where mishaps or errors occurred. We have deliberately provided more of the latter to illustrate the many ways in which spoken communication can go awry.

Challenge 1: The communication environment

What does good look like?

In the ideal communication environment, there is adequate time, privacy and comfort. There are no distractions or interruptions. Clinicians and patients are relaxed and do not feel under pressure.

Example 1.1 of a good environment for spoken communication

"It was evident there is a high standard of communication and trust between the staff and positive working atmosphere which reflects positively on us, the patients. I was surprised and taken aback by the availability of doctors on the ward and the fact that nurses were proactive and continually asked patients if they needed anything rather than reluctantly responding to a buzzer call. Nothing seemed to be of inconvenience to any of the staff. The positive and infectious attitude of the staff was incredibly comforting as a patient."

From Care Opinion website

Comment: This appreciative patient has summarised a near-ideal environment for effective spoken communication.

What problems can occur?

Inappropriate environments for communication, time constraints and overworked staff were common themes in our dataset. In many patient accounts, there was a perception that wider system pressures had led to clinicians not being available to communicate, not attending fully to their concerns and (in some cases) unable or unwilling to engage emotionally. In some cases, patients felt that they were a burden, so did not speak up. The following specific problems and issues should be addressed:

- 1A 'Contextual noise' such as a busy front-office setting, beeping alarms, phones going off or other distractions.
- 1B Lack of privacy when important or sensitive topics are discussed.
- 1C Staff member is unable to listen attentively, e.g. because they are tired or stressed, have insufficient time, are frequently interrupted or have competing demands.

Poor environment for spoken communication: example 1.2

"The doctor spent the entire consultation either looking at the computer screen or talking into his dictating machine. The doctor took two telephone calls, one of which was personal, while I was in the room."

Patient representative at consultation workshop

Comment: New technologies have an important place in healthcare, but they can be distracting. As this example illustrates, attending to the technology at the expense of the patient is also discourteous.

Challenge 2: Information exchange

What does good look like?

Good information exchange occurs when accurate and appropriate information is exchanged between the right people at the right time and all parties confirm (correctly) that the others have understood.

Example of good information exchange: example 2.1

Surgeon: "Stitch scissors please, in my right hand."

Research data (Bezemer 2011)

Comment: This surgeon, communicating in the stressful environment of an operation, gives very specific instructions (this is important because the theatre tray contains many different kinds of scissors). The scrub nurse is likely to be in no doubt about which instrument the surgeon needs or where to pass it (though she could confirm understanding by saying something like "scissors, right hand" as she passes them).

Example of good information exchange: example 2.2

It's important – but sometimes difficult – to be able to say (something like) 'I'm really worried'. This can be a powerful statement in terms of getting someone to take you seriously. Sometimes this statement can even be more important than giving the 'objective' information about a patient.

From consultation workshop with NHS staff

Comment: This staff member points out that in safety-critical situations, a clear statement of the level of concern is as important as the detail of specific observations or test results.

What problems can occur?

Inadequate information exchange between clinicians, leading to safety-critical misunderstandings or delays in care, was the commonest problem with spoken communication in our analysis of postings to the CareOpinion and HealthWatch databases. Poor information exchange has also been highlighted by the National Reporting and Learning System, General Medical Council (2007, 2013) and professional indemnity organisations as a key factor affecting patient safety. As noted above, poor information exchange is more likely when there is contextual noise, pressure of work, tired staff and multiple distractions. Specific problems and issues identified in our datasets included:

- 2A Omission e.g. key information was needed but not supplied.
- 2B Lack of clarity e.g. speaker used jargon, acronyms or euphemisms (perhaps inadvertently, or to avoid an awkward moment), or the information given was incomplete or conflicting. Even small response words like "OK" can be misunderstood.
- 2C Over-scripting e.g. speaker relied too heavily on a structured tool, protocol or checklist (for example using a bureaucratic 'duty of candour' response rather than simply saying sorry).

Over-scripting may result in a one-sided conversation with inadequate reflection and responding by the receiving party.

- 2D Information overload e.g. information was accurate and complete but key points were not adequately highlighted so went unnoticed.
- 2E Information was given but not adequately received or processed, perhaps because of linguistic, cognitive or physical factors (e.g. limited English, learning difficulties, deafness). Groups with particular needs are considered further in Challenge 6.

Poor information exchange: example 2.3

“A patient was brought up to (ward) from A&E on BIPAP (bi-level positive airway pressure). I had no prior warning nor was I asked if I was ready. The bed he was allocated had no oxygen tap in place and we had no spare at hand. This caused a major disturbance as I had to move patients around. The A&E nurse was away from A&E for 40 minutes when it should have been approximately 15 minutes. I had no time to get BIPAP set up in the bay first. The remaining 3 patients who are also at risk of deterioration were put at further risk as everything had to be stopped to accommodate the unexpected arrival of the new patient.”

Nurse account, National Reporting and Learning System

Comment: In this example, significant disruption and waste of staff time occurred because no spoken communication occurred to warn a hospital ward that a very sick patient was being transferred. Crucial support (oxygen) was not ready and care of other sick patients was deprioritised to put this in place. A simple, timely phone call would have prevented this escalation and the knock-on risks to other patients. This is one of many examples from the National Reporting and Learning System of patients being transferred to wards without key information needed for planning care (e.g. that the patient was confused or had high dependency needs).

Poor information exchange: example 2.4

“Patient attended GP practice with partner, presenting with chest pains. Receptionist called through to GP to advise that patient had contacted with chest pains. Miscommunication identified as GP had assumed patient was on the telephone. Advice was given for the patient to dial 999. Patient and partner given advice and left surgery. Patient subsequently identified to have suffered a heart attack.”

GP account, National Reporting and Learning System

Comment: In this example, the receptionist conveyed the patient’s symptoms accurately but omitted to tell the GP that the patient was physically present in the surgery. The GP omitted to ask, and presumably assumed they were phoning from home. The GP’s advice to call 999 would have been appropriate had the patient been at home but could have had life-threatening consequences in the circumstances described.

Poor information exchange: example 2.5

Older gentleman with type 2 diabetes, found to have raised blood pressure. Commenced on treatment, returned after a month as instructed and still had high blood pressure. He had “finished the course”.

Clinical example shared by GP in working group

Comment: In this example, the patient thought he had been prescribed a short course of tablets, not regular medication for the foreseeable future. It would have been helpful to check that the patient had understood this, and also to explain the importance of blood pressure control in the context of type 2 diabetes. Written information to reinforce the spoken message would have helped.

Poor information exchange: example 2.6

A patient was scheduled to undergo a very complex spinal surgical operation. The surgeon was a known expert in dealing with such complex cases. On the day of the surgery, anaesthetist 1 (who routinely worked on such cases with this particular surgeon) was sick. Anaesthetist 2 was brought in to anaesthetise this patient. The surgeon did not explain the complexities of the planned surgery to the anaesthetist 2, who concluded from the case notes and the theatre list that this was a routine case of average complexity. This contributed to lack anticipation of the potential blood loss on the part of anaesthetist 2, with consequential delays in arranging blood for rapid replacement in the theatre. The patient suffered massive blood loss and subsequently died.

From a coroner's report

Comment: This example illustrates a recurring theme about communication in reports of patient deaths – an assumption on the part of one clinician that the other has 'got the message'. The surgeon and the regular anaesthetist worked from shared understandings that did not need to be made explicit. But because of the last-minute change of anaesthetist, a more explicit explanation of the complexities and risks of the case (perhaps with checking back to confirm understanding) was needed.

Poor information exchange: example 2.7

Doctor I'm not worried about his breathing too much

Mother oh what is ...

D I think that's I mean sometimes sometimes they make this noisy breathing because actually relative to adults ... the calibre of the airways ... the the the size of the openings of the airways ...

M mm

D ... is reduced in comparison to how much air they need to move so the the airflow is quite turbulent ... so it makes a noise

M mm

Research data (Roberts and Moss 2003a)

Comment: In this baby clinic, the doctor explains to the mother why he is not concerned about her baby's noisy breathing. He interrupts her first question and then gives an explanation that is hard to understand because it contains too much medical jargon. The mother gives only minimal responses ('mm') and it is not clear whether she understands the doctor's explanation.

Challenge 3: Attitude and listening

What does good look like?

A good clinician demonstrates the following attitudes towards his or her patients and colleagues: respect, commitment, positive regard, empathy, trust, receptivity, honesty and an ongoing and

collaborative focus on care. Listening occurs most readily in situations where there is adequate time, privacy and comfort (see Challenge 1), and when clinicians are committed to the patient's care and emotionally attuned to the needs of patients, carers and staff.

Appropriate attitude and good listening: example 3.1

"Mr X- has been nothing but kind, honest, and helpful. Explaining the procedure fully, including risks, I was able to make an informed choice with regards to yet another surgery (my 9th), something I was apprehensive about."

From letter of appreciation sent to local Patient Advice and Liaison Service

Comment: This example illustrates the important point that not only is a professional attitude (kind, honest, helpful and willing to spend time explaining) appreciated but it helps the patient make an informed choice about major medical decisions.

Appropriate attitude and good listening: example 3.2

Dr Kate Granger, a hospital doctor who became a cancer patient, was infuriated by the number of NHS staff who failed to introduce themselves. She started a social media campaign called #hellomynameis, aimed at ensuring that staff always introduce themselves by name.

Comment: Dr Granger, who died in 2016, was convinced that personal introductions set the stage for a respectful and honest spoken encounter.

Appropriate attitude and good listening: example 3.3

Doctor Hello

Patient Hello

D Good morning

P Good morning - feeling very tired and I feel dizzy most of the time if I look up then I seem to feel - lose the balance erm pressure of w- of erm work I had to come in Saturday and Sunday to try and you know tidy up my in-tray erm I'm also having pressure at work from the manager pushing- pushing all the time she just rang me twice on the mobile I had a duty last night and I didn't finish until seven and twenty-five and then knowing that I had an appointment with her this morning so she rang me up just being bullied for the last four months in the office and erm I'm going ((starts crying)) sorry I'm going through a marriage break-up with my husband

[patient continues for 5 minutes during which time the doctor hardly speaks]

D: okay now you've got lots and lots of things going on - how do we deal with them because with the work do you want to take some time off work which we can put down as as tiredness dizziness er to give yourself a bit of a breathing space

D all right we'll meet again and try and get through some of these issues because I think there's a lot going on I think in terms of workplace bullying I think you need to be quite strong about this

P ((nods))

D and you need to maybe just write to her and to say just so it's on record that you're feeling bullied

P right

D all right just and leave it at that

P okay

D don't do any more don't write any- the shorter the letter the better

P all right

D *in my experience*
P *okay*
D *you need a break cos you're very tired and that's what's making you dizzy*
P *okay*
D *and then we need to talk about your husband or your ex-husband because I'm worried that he's making threats*

Research data (Roberts and Atwell 2006)

Comment: This is the opening section of a 5½ minute story told by the patient of her numerous difficulties. The only interventions by the doctor are to hand her some tissues, show non-verbally that she is listening closely and ask once for clarification. The GP creates an environment in which the patient can disclose her feelings and can cry without being interrupted. The doctor does not attempt to deal with all her problems at once but, after these 5½ minutes, suggests immediate action to deal with one of them (harassment at work). She maintains a sympathetic environment while also giving precise instructions: 'I think you need to be quite strong', 'I think you need to maybe just write'. The potential threats from the husband need more time in a further consultation.

What problems can occur?

Complaints made by patients about clinicians' communication, and those made by staff about colleagues, very often boil down to allegations of unprofessional or dismissive attitude. The General Medical Council and professional indemnity organisations identify persistent failure to listen to patients or explain things to them, failure to get on with colleagues, and rudeness as significant contributors to safety-related adverse patient outcomes (GMC 2017, DJS Research 2015, MPS [undated], MDU 2012). One review article, covering 59 studies of 88,000 complaints, identified communication (both spoken and written) as a major safety issue (Reader et al 2014). Our own dataset confirmed these impressions: many accounts of poor communication described the clinician as rude, dismissive or uncaring. More specifically, we found numerous examples of the following:

- 3A Dominating the conversation e.g. not granting a patient or colleague the opportunity to put their view or share in decision-making.
- 3B Disbelieving or dismissing what a patient or colleague says, or not taking them seriously.
- 3C Real or apparent lack of compassion – e.g. failing to acknowledge or respond to another person's distress.
- 3D Managing tensions or conflict in an insensitive or unproductive way e.g. by refusing to talk about the topic or attempting to coerce.
- 3E Lack of engagement – e.g. failing to seek or provide all the information needed to give appropriate care.

Attitude and listening problems: example 3.4

"Terrible. Treated like a nuisance. Felt unable to express anything. Being 26 with widespread inflammation and severe pain, I was struggling psychologically with the condition. The rheumatologist I saw at X- hospital, after seeing me break down in tears, not just from physical pain, responded with 'Yes, ok.' No more was said, no information on support groups or organisations, no empathy, horrendous bedside manner! I now refuse to attend any rheumatology appointments at X- hospital."

Patient's account via HealthWatch database

Comment: In the absence of empathy and emotional engagement from the clinician, this patient with a newly-diagnosed chronic rheumatological condition feels so humiliated and unsupported that she decides to default from attending the clinic altogether. It is also worth noting that in addition to failing to acknowledge the patient's distress, the doctor also failed to provide key information on how to cope with her illness (see Challenge 2).

Attitude and listening problems: example 3.5

"They wouldn't listen to me. I could feel myself slipping back into a coma but I was determined I wasn't going to go there, and all I could say was 'Cortisone, coma, Cortisone, coma' sort of thing but nobody would listen to me 'cause they said they had a process they had to go through to find out what was wrong with me. So without looking at all the emergency treatment and procedures I had they kept on going through ECG and all that sort of thing and I was still trying desperately to get them to give me the Cortisone injection cause it works immediately and that is all I needed."

Patient with Addison's disease, research data (Iedema 2008)

Comment: This case illustrates how the patient's experiential knowledge can be an important factor in safety-critical situations. Addison's disease is very rare, but most people who have it will know it is crucial to take some cortisone promptly in a crisis. Doctors who adhering rigidly to a generic checklist even when the patient is telling them – with some urgency – what emergency treatment is needed are not being 'evidence-based' because they are ignoring the patient's own evidence. Of course, it would be appropriate to verify what the patient is saying, but it is poor practice to simply ignore their contribution.

Attitude and listening problems: example 3.6

A patient had short-term memory problems following brain injury. He was admitted to hospital, and staff tried to communicate directly with him. He kept saying "Yes" and "I understand", so staff felt they were getting through to him. But his partner knew that this was a social front and the patient didn't really understand at all. She tried to explain this to the staff, but they replied "we can't talk to you, we are only allowed to talk to the patient".

Example shared at consultation workshop with NHS staff

Comment: This case illustrates a overly rigid approach to the general principle of addressing the patient rather than the relative. If staff had taken a more common-sense approach, they would have at least sought to verify or refute what the man's partner was telling them.

Challenge 4: Aligning and responding

What does good look like?

Alignment means that both speakers share assumptions about what is appropriate behaviour, what information needs to be exchanged and how, and what particular words and phrases mean. For effective communication, both parties need to recognise and adapt to each other's spoken and unspoken needs and expectations. This interpersonal alignment is an ongoing, unfolding process that enables the conversation to flow and evolve, not a one-off 'check'.

Good aligning and responding: example 4.1

This elderly patient has come to tell the GP about her ordeals with the antibiotics he prescribed her and how she survived them.

P *one day I was very bad with terrible pains*

D *mm*

P *sickness you know – everything you could get with it I think I got*

D *you had a full house did you*

P *oh God*

[...]

P *yes I went off food I was never going to eat again*

D *you were never going to eat again you made a pact did you*

P *yeah never going to eat again*

D *when was the last time you actually were sick when you vomited ... how long*

P *about on the Thursday or Wednesday*

D *right*

P *I haven't been sick since then and the indigestion is gradually going as well*

[...]

D *right good well done*

P *yeah*

D *we did think it might be a bit of a problem*

P *If doctor P says you've got to go on more of those*

D *you might argue with him*

P *just let me die just let me die*

D *right*

[...]

D *do you remember I – we did the blood test and I thought there was there the- showed that there may be an infection*

P *yeah yeah*

D *called helicobacter*

P *that's right*

D *and so the antibiotics there's two different kinds of antibiotics are to try and get rid of that infection*

P *yeah*

D *cos the thinking is that the presence of the infection is one of the reasons why people get recurrence of*

P *yeah*

D *indigestion*

P *if ever there's a cure worse than the illness its that*

Research data (Roberts and Moss 2003)

Comment: Pitching at the right level of formality, shared rhythms and intonation, careful choice of metaphors and using humour appropriately all help health professionals and patients to get on and feel comfortable together. This patient presents her suffering humorously by exaggerating her reactions to the antibiotics and the GP responds in a humorous way, matching her mood. But he also moves the consultation swiftly on by asking specific questions about her symptoms. Because he has tuned into her mood and used humour like her, these questions don't sound abrupt. He also gives her the right level of explanation about the tablets. He doesn't patronise her with a vague explanation but is careful to signpost technical terms – 'it's called helicobacter' – in a way that shows he has tuned in to what she may not know.

What problems can occur?

Patient safety may potentially be jeopardised by a number of difficulties in aligning and responding:

- 4A Different assumptions e.g. patient misreads clinician's intentions or vice versa.
- 4B Different styles of communicating e.g. when clinician and patient do not share assumptions about how direct or indirect (or how polite or casual) to be, or use of vague language.
- 4C Mis-matches of meaning, when a word means something different to the clinician and the patient (e.g. "I was sick" can mean "I was unwell" or "I vomited").
- 4D Diverging goals or interests – e.g. when the clinician's speech relates to outcomes that do not matter to the patient.
- 4E Incorrect assumptions about another person's ability to understand terminology or act on what is said – e.g. assuming that a healthcare assistant is a trained nurse or that the carer of a person with learning difficulties can understand medical jargon.

Poor aligning and responding: example 4.2

"I had never used gas and air before and needed guidance from the nurse whilst in the procedure room. I tried to 'suck and blow' on the gas and air tube but could not get it to work correctly. The nurse tried to tell me how I needed to blow on the tube and told me that I was not blowing 'right.' I didn't have a clue as to how to get it right. With some exasperation, she said that I needed to 'make a sound like Darth Vader.' I know that Darth Vader is a character from Star Wars but I have never seen the film and have absolutely no idea what Darth Vader sounds like. I had no idea what the nurse was talking about and with the tube stuck in my mouth couldn't really explain that I didn't know what she was talking about. I also felt that I ought to have known what Darth Vader sounded like."

Patient account via patient representative

Comment: This example illustrates failure of communication based on an incorrect assumption about what the patient knows. The example also illustrates how, in a situation that is both unfamiliar and anxiety-provoking, the patient may be reluctant to admit that she does not understand the instruction.

Challenge 5: Creating the preconditions for effective communication within a team

According to a report by the Royal College of Physicians (2017), good team working has been shown to reduce medical errors, increase patient safety and improve patient mortality rates. It also leads to better staff outcomes including reduced stress and improved job satisfaction.

What does good look like?

Effective communication within a team occurs when there is an open, trusting and mutually respectful ethos and when anyone in the team, however junior, feels able to raise concerns or point out problems. If these conditions are met, safety concerns are more likely to be surfaced and dealt with.

Creating an environment for effective team communication: example 5.1

"Dr X was the consultant overnight, he was available at the end of the phone and took time to explain very clearly to the registrar overnight the child's condition, and what treatment was needed whilst also explaining in great detail what this treatment would do. At the start of the

shift he also took the time to explain it to myself and also at the end of the shift he said thank you before I went home for my efforts overnight. He was very welcoming, friendly, open and approachable, whilst also remaining professional and didn't make me feel stupid when asking questions. He took his time to explain everything in detail which led to the patient receiving the care they needed and ensured treatment was given swiftly and effectively."

Nurse account
The Learning from Excellence initiative

Example 5.2

"The rigorous debate in the meeting was impressive e.g. when discussing the date for discharge for Mrs Hughes when Joanne (physio) clearly stated why she disagreed with Paul (consultant) when he said Mrs Hughes could go home Friday. Paul had somewhat reached the decision just by reviewing how Mrs Hughes was progressing in terms of 'medical markers' (U&Es, compliance/tolerance with medication) but Joanne soon pointed out the limitations experienced when Mrs Hughes was walking and with her overall posture and strength. There was no sense of 'one-upmanship' in any of this though, and the debate was very direct but not abrupt and was all about the patient rather than 'scoring points'."

Research data (Jones et al 2011)

Comment: These examples both illustrate psychological safety. In example 5.1, the consultant has *made himself available*. He values his staff and takes time to explain a complex treatment regimen at handover. He is aware of how his junior staff may be feeling, and makes the effort to create a climate of support in which people feel able to speak up. The inexperienced clinician feels able to admit ignorance or uncertainty and contact the consultant for further advice. In example 5.2, a similar positive climate allows the physiotherapist to challenge the consultant in a multi-disciplinary team meeting, preventing a premature discharge.

What problems can occur?

A report from the Royal College of Physicians (2017), research into operating team briefings (Whyte 2009) and a book chapter on team resilience (Bowers et al, 2017) were some of the sources from which we identified the following recurring issues in communication within a team:

- 5A Less senior or less powerful staff do not contribute to a conversation (either because senior members do not listen to them or do not value their input, or because junior members do not feel they will be listened to). Some accounts in our dataset suggested that staff from minority ethnic groups and women in particular may be under-confident to speak up in a team setting and that titles such as 'Dr' or 'Professor' may silence those who lack such titles.
- 5B Less senior or less powerful staff hold back from asking questions and do not raise concerns because teams are run in a hierarchical way with low psychological safety. Some interventions designed to address this problem (e.g. safety huddles in which staff are told "there are no stupid questions") may be helpful but others (e.g. approaches that emphasise inflexible procedures rather than adaptive action) may be ineffective and even counterproductive.

Low psychological safety leading to non-communication: example 5.3

A patient was in theatre for a Caesarean section. The patient was awake and her partner was also present. The surgeon began to close the wound despite the nurse stating that the swab count was wrong. No other staff member challenged the surgeon.

Example shared at consultation workshop with NHS staff

Comment: This account illustrates how safety-critical incidents can escalate when nobody has the confidence to challenge the over-confident but inappropriate behaviour of the most senior member of the team. The staff member telling the story commented “other than rugby tackling him, what could they do?”.

- 5C There is uncertainty and/or conflict among or between teams e.g. lack of agreement on a decision and also no systematic approach within the team for resolving such problems. In such circumstances, specific conversations on a topic may or may not occur.
- 5D Staff members communicate well with others of the same profession but less well with staff from different professions.

Poor preconditions for team communication: example 5.4

“Patient was GCS 3 [Glasgow Coma Scale 3 – indicating very sick] when staff arrived this morning. She was For Resus and for full escalation at the time. Handover given by SN [staff nurse] X was News 0 GCS 14/15 [indicating not very sick]. I was informed by HCA [healthcare assistant] Y that she was concerned about the patient throughout the night because the patient didn't look well and breathing isn't normal. HCA escalated this to nurse several times but she wasn't concerned. HCA also mentioned that when she washed the patient in the morning, the patient was very drowsy. She escalated this again to nurse X but she didn't do anything again.”

From National Reporting and Learning System

Comment: In this example, at least two safety-critical communication issues are evident. First, the staff nurse appears to have reported an incorrect score on the Glasgow Coma Scale, which conveyed the incorrect impression that the patient was not very sick. Secondly, she repeatedly dismissed the concerns of a healthcare assistant, who – notably – had been caring closely for the patient for several hours. It is also noteworthy that qualitative clinical impressions (that the patient “didn't look well”) seem to be given less weight than what was in this case an incorrect quantitative status score. From the information given, it is impossible to be sure why the assistant was ignored, but a hierarchical culture and an element of professional tribalism may have contributed.

Challenge 6: Communicating with specific groups

Additional care needs to be taken when communicating with groups such as children and young people, people with problems understanding (e.g. learning difficulties, cognitive impairment), people with mental health conditions, limited English speakers and people with hearing impairment.

What does good look like?

All the principles of good communication outlined above still apply. Extra time, along with a flexible, personalised, context-sensitive and holistic approach is needed: one size does not fit all. Communication with children needs to be age-appropriate, non-patronising and generally addressed primarily to the child, not the parents. With patients who have difficulty communicating, it is important to convey that we are trying to understand them; to use positive, friendly language; and to think carefully about how to frame questions. Patients with learning or comprehension difficulties may need considerable extra time; they like the clinician to communicate directly to them, not their carer; and they value the use of pictures, models or digital communication aids alongside spoken communication (Smith, 2016). Some mental health conditions may influence the patient's ability to communicate what is wrong and understand and comply with advice and treatment.

Patients with limited or no hearing may prefer text messaging or emails to phone calls, and may wish to have key information written down. Effective communication through interpreters (including those who use sign language) is characterised by a high degree of trust in the interpreter by both parties; accurate and sensitive translation; and cultural competence (e.g. recognising and attending to the social, cultural and religious background of the patient and family). Patients with limited English may have poor knowledge of the system and be confused and frightened. It is particularly important to convey warmth, respect and empathy; provide clear and complete information; check understanding; and provide adequate time and appropriate body language to allow the patient to raise concerns and issues. Clinicians who work through interpreters need to allocate sufficient time not just for translating what is said but also for adapting to cultural needs and nuances. Interpreting is a three-way social interaction in which professionalism and sensitivity (as well as common sense) are key. In our multi-cultural NHS, many staff members speak English as a second language. It is therefore especially important to speak clearly, avoid idioms and use check-back. (NHS England, undated)

Good communication with person with mental health needs: example 6.1

"I'm sure you are getting a lot of negative stories so I thought I'd send you this one too. In terms of great communication – my GP now and my pharmacist have been incredible. At one point I was incredibly paranoid about taking medication and would either not take [my medication] or take it all at once. Obviously neither of these options was great. My GP and pharmacist worked together and with me, and they made it so I could pick up my meds every day and take it with my pharmacist. This happened for a short while until we built up to me taking weekly prescriptions home."

Patient with mental health needs, via patient and public involvement email list

Good communication in an interpreted consultation: example 6.2

"She's going to have the baby at X— hospital and they haven't explained anything to her, so I explain: 'Your baby will have the Vitamin K, your baby will have the BCG and it's for you to ask for the red book'. And then she was very happy, she was very relaxed, the doctor was quite happy. And then she cuddle me and she said: 'Thank you very much, I was so scared, I was so frightened'." – Spanish-speaking interpreter

Research data (Greenhalgh et al 2006)

Comment: In both these examples, the different professionals involved follow all the principles of good spoken communication described in previous sections. In addition, they take extra steps (spending more time, offering additional reassurance, taking account of the patient's capabilities and perspective) to accommodate their particular needs. The patient was able to trust the staff member(s) and feel supported by them, understand what was being communicated and comply with recommended treatment.

Good practice for supporting people with learning difficulties: example 6.3

Within Mid Yorkshire Hospitals, patients with learning disabilities complete a 'hospital passport' which supports the tailoring of spoken communication to the individual. The 'passport' lists basic details about the patient such as name, ethnicity and religion as well as a section where patients or their carers can list 'things I like to do and talk about.' The passport also contains a section on 'how I communicate' describing techniques that can be used to help them understand e.g. photos, point board, easy read documents.

Comment: Everyone is different. A personal 'passport' allows the individual to make their needs and preferences clear, and provides an opportunity for staff to individualise care (including how spoken communication happens).

What problems can occur?

- 6A When communicating with children, failure to address the child's specific communication needs (e.g. ignoring or patronising the child, or using inappropriate tone or language).

Poor communication with children and young people: example 6.3

"He said my daughter's hearing was fine and there were no issues. I was extremely relieved about this but it would have been nice if he had been more personable and taken the time to explain why this was the case...maybe even speaking to my daughter considering it was her ears we were talking about? My daughter's appointment felt more like a lesson for the students rather than an appointment being made for her benefit."

From patient and public involvement group

Comment:

This comment from a patient's parent highlights one communication problem that is child-specific (talking to the parent rather than the child) and two that are generic (the doctor was not "personable" and he seemed more interested in the students than the patient).

- 6B When talking with people with communication difficulties, learning difficulties or cognitive impairment, failure to adjust response to reflect the person's level of comprehension.

Poor information exchange with a patient with a specific communication difficulty: example 6.4

A woman with autism was admitted to hospital after a fall at home. Because of her autism and the stressful experience, she was unable to speak to her clinicians. However, she was able to use WhatsApp for communicating with family members. The clinicians did not realise that the woman had a specific condition; they assumed that she was being rude by not talking to them, since they could see that she was able to communicate using her phone. Furthermore, the clinicians passed negative assessment of this patient to other staff at handover.

Example shared at consultation workshop with NHS staff

Comment:

In this example, the clinicians did not consider the possibility that the patient was *unable* to speak. Rather, they interpreted her behaviour as a socially inappropriate *refusal* to speak. This created the erroneous impression that the patient was wilfully being difficult, which was passed onto other staff caring for her. The opportunity to think creatively about how to communicate with this patient was missed.

- 6C When communicating with people with mental health conditions, using stigmatising or dismissive language ("she's going off on one", "that's a stupid thing to do"), failure to take the person's physical condition seriously (our examples included a mental health inpatient with diabetes asking for insulin but not receiving it, and a perforated appendix in a mental health patient whose abdominal pain was ignored), or failure to address or accommodate how their condition affects their understanding or behaviour.

Poor information exchange with a mental health patient: example 6.5

"Wherever I have lived, it is very unclear who I am supposed to call in a crisis. Everyone (GPs, MH [mental health] people) has said something different and I have had to scribble down what

they have said but it has all got lost and the information is not easy to find online (especially when actually in a crisis). I'm also not sure what counts as a crisis and when I should call if I feel like I am in one. Whenever I have spoken to GPs, nurses, or mental health professionals I have just been told to call so and so in a crisis, but they've never explained to me what constitutes as a crisis. I have never called even if I feel like I am in one because I don't want to get it wrong and waste someone's time. I feel like it would work better if I knew who to call and when!"

From patient and public involvement email group

Comment:

In this example, the patient appears to have received conflicting and confusing information from different health professionals, but no co-ordinated advice or plan that all her care professionals have agreed. Nobody has given her a clear explanation of what counts as a mental health crisis – something that is likely to be hard for a person to spot when they are in the middle of one.

Poor attitude and listening to a patient with a mental health condition: example 6.6

The following quote is from a patient with a mental health condition who experiences dissociated states in which she inserts staples into parts of her body; because of the dissociation she is unaware of this at the time. Below, she describes an A&E visit for leg pain.

"The doctor's attitude from the start made me feel uneasy. He looked at my leg, and without getting close to it or even touching it, he told me the staples were not causing the pain I was experiencing. How did he know?"

He then went on to tell me that I had to stop doing this and that I can't keep putting things in my leg and then coming to them expecting them to remove them as they don't typically remove staples. At that moment, I felt my eyes sting. But I refused to cry in front of him. The nurse and the other 3 doctors in the room simply stood and stared at me. I felt so humiliated and belittled. I wanted to explain the nature of dissociation to him, but I feared that if I spoke, the tears would start. He didn't check for signs of infection, or bother to ask me about any other symptoms I've been experiencing. One of the other doctors then asked me about my medical history, medications etc. Then I was sent home. As soon as I stepped off the ward, the tears poured from my eyes. How could he be so ignorant? He clearly had no understanding of mental health, dissociation and self-harm."

From patient and public involvement group

Comment: This example illustrates a dismissive (and perhaps even discriminatory) attitude towards the mental health elements of a complex condition. From the patient's point of view, she has a dissociative state which leads to self-harming behaviour that she cannot control at the time, and which in this instance has led to pain and possible infection in her leg. From the clinician's perspective, the patient is deliberately inserting staples in her leg and then turning up to have them removed, which (this doctor believes) is inappropriate as "they [the A&E department] don't typically remove staples". The doctor – and the other clinicians in the room – fail to acknowledge or show compassion for the mental health condition that has led to the physical problem on which they exclusively focus.

- 6E When communicating with the hearing impaired, failure to make optimum use of communicative technologies, inadequate or imprecise translation or failure to check back for understanding.

Miscommunication via British Sign Language: example 6.7

A patient who had been treated for cancer in the past was told by her doctor that the cancer had spread to her arm. The sign language interpreter used a full hand gesture to indicate that the cancerous cells were in her arm. The patient interpreted this as cancer in her whole arm and assumed that she had now had only a few months to live. In a later consultation, it transpired that the cancer was limited to a few cells near her elbow. If the interpreter had waited to elicit more detail from the doctor, she would then have used a pointing gesture to specify the precise location and extent of the cancer.

Research data (Stone 2010)

Comment: Spoken English tends to start with generalities and then home in on specifics (e.g. “the cancer is in your arm – but it’s just a few cells in your elbow”). British Sign Language (BSL) tends to do the opposite – focuses on specifics first (“the cancer is here in your elbow [which is part of your arm]”). In this example, neither the interpreter nor the doctor realised the extent of the miscommunication or how it had affected the patient.

6D When communicating with limited English speakers, there may be

- Problems with clinicians (unwilling to spend extra time even when interpreter available, failure to seek patient’s perspective, failure to engage across a socio-cultural divide; our focus group data provided several examples of perceived racism or lack of engagement by doctors and nurses)
- Problems with professional interpreters (unavailable, not trusted by the patient, fails to translate accurately or convey key nuances)
- Problems with family member interpreters (is rejected by professionals, or fails to translate accurately, selectively translates to pursue own agenda, is a child)
- Problems when trying to ‘get by’ in English (leading to poor information exchange, misinterpretation of symptoms, illusion of understanding, misuse of idiomatic language e.g. ‘down below’ rather than ‘vagina’)
- With staff do not speak English as a first language, overuse of idioms and failure to check understanding

Family member interpreter rejected by professionals: example 6.8

An 82 year old patient with no English became acutely unwell and was admitted to hospital. Her daughter in law, who wished to stay with her, was sent home and told that “we will get an interpreter if she needs one”. The patient later wet the bed so buzzed for the nurse. In her daughter-in-law’s words, “The nurse did not understand her so left her as she was and went away”. No interpreter was called.

Focus group data

Comment: This account, by the daughter-in-law of an elderly patient, highlights that family member interpreters are often trusted by their relatives and keen to support them in their encounters with the NHS. Whilst it is not always appropriate to place a family member in the

position of interpreter, in this example the promised professional interpreter did not materialise and the patient received suboptimal care.

'Getting by' in English leading to misunderstandings: example 6.9

This patient, who was bitten by a dog while on holiday in Nigeria, attends his GP.

GP: *what kind of dog was that - it was somebody's dog?*

Patient: *yes somebody's*

GP *it was a stray dog*

P *no no it was somebody's dog*

GP *right*

P *yes I made an enquiry they said that- they they told me the dog go to the vet regular*

GP *right okay*

P *but that's what they said*

GP *right right right so did you know the owner or did*

Pt *I know the owner*

GP *oh fair enough so*

Pt *erm ((laughs)) but*

GP *did you see any doctor then*

Pt *no*

Research data (Roberts 2009)

Comment: The GP explores the circumstances with a view to deciding whether a rabies immunisation is necessary. He is told the dog reportedly sees a vet regularly, and the patient knows its owner. The GP appears satisfied the evidence is authoritative - he says 'oh fair enough so'. Later in the consultation he suggests to the patient that immunisation is not indicated. However, during the early stage of history taking shown above, the patient implies that he is not convinced that the dog is free from rabies ('they told me the dog go to the vet regular but that's what they said'). In British English, stress would be used to convey this suspicion. Stress would emphasise the verbs 'told' and 'said': 'they *told* me the dog goes to the vet regular, but that's what they *said*' (implication: and not what they actually do). The patient also hints at his sceptical perspective by using the word 'but' twice and by the use of a hesitation marker and laughter. The patient leaves without immunisation.

Unprofessional interpreter: example 6.10

A male Lithuanian interpreter was asked to interpret for a young female patient. Each time a long question was posed by the clinician to the patient, the interpreter would shorten it and vice versa (when the patient made a long response, the interpreter would give a short response). During the consultation when the clinician asked the patient a sensitive question, the interpreter responded directly to the consultant to say that 'women don't do that'.

Example shared in focus group of limited English speakers

Comment: An interpreter is not a bilingual translating machine. Interpreters also attend – more or less professionally – to the personal, social and cultural material situation being discussed. Sometimes, as in this example, they put their own gloss on the words they translate. It is noteworthy that in this situation the poor communicative performance of the interpreter is evident to the clinician and the patient because of the discrepancy in length of utterances. Confidentiality and trust have been eroded and good clinical care is impossible.

Safety-critical misunderstanding by staff member recently arrived in UK: example 6.11

A clinician was handing over the care of a very sick patient to another clinician who had only recently immigrated to work in the UK. The first clinician communicated objective information (e.g. test results, observations) very calmly and slowly, and showed no emotion when describing the state of the patient. The second staff member understood the words spoken but interpreted the message to mean that the patient was not especially sick – hence did not attend closely to the patient.

Example shared at consultation workshop with NHS staff

Comment: This example illustrates that it is not merely *what* is said but *how* it is said that conveys crucial aspects of meaning (specifically, a staff member's concern that a patient is very sick). The person giving the handover is following UK professional custom and not showing emotion or agitation. The person receiving the handover has recently worked in a setting where a very different style of communicating would have been used to convey concern about a sick or deteriorating patient. The misunderstanding may have been avoided if the first staff member had used check-back and/or been more attuned to wider cues about the other's level of understanding.

Discussion

Summary of key findings

The Patient Safety Initiative Group has reviewed hundreds of examples of safety-relevant spoken communication interactions, between patients and staff, or among staff, in the NHS. We have found examples of both good practice (which may have saved lives) and poor practice (which may have placed patients at risk). Some examples of safety-critical communication failures appeared to be associated with individuals who consistently failed to communicate clearly, effectively or politely. However, we also found many examples of the kind of communication failure that could happen to almost anyone where the circumstances are challenging, the communication setting is less than ideal or the person doing the communicating is having a bad day. In all these situations, patient safety could be imperilled by a few words not said (or said in a way that is confusing, inappropriate or difficult to engage with) or by flawed assumptions about how much the other party(ies) have understood.

We have identified six key challenges affecting everyday spoken communication: the communication environment (which should ideally provide adequate time, privacy and comfort for spoken communication), information exchange (relying on adequate and appropriate information to be passed between the right people at the right time), attitude and listening (respect and attentiveness have proven safety-critical benefits), aligning and responding (good conversations benefit from a parallel channel via which speakers continually check understanding and orient to how the other is reacting), creating the preconditions for effective team communication (everyone must feel confident to speak up about lapses or threats to coordination and continuity), and communicating with specific groups (additional care and communication are needed, for example, for children and those with limited English, impaired hearing, limited capacity to understand or a mental health condition).

Our findings strongly support the conclusion that spoken communication should be thought of not merely as the transmission of information but as context-dependent social interaction shaped by roles, relationships, expectations and hierarchies and by the wider pressures and distractions of a busy care environment. Tools and checklists intended to improve it have a place but they really only impose an artificial structure on natural speech, and strict adherence may have adverse consequences.

Practitioners may derive guidance from such scripted resources, but communicating appropriately, effectively and attentively will require them to commit to becoming *reflexive communicators*.

Challenges are complex; solutions will not be simple

The examples we reviewed included some relatively straightforward problems (such as excessive use of jargon) for which there are obvious solutions that either already exist or which can probably be developed relatively quickly and implemented across the NHS. But we also identified more complex problems: dismissive attitudes, lack of psychological safety in multidisciplinary teams, 'tribalism' among professional groups, and a lack of commitment to resolving complex situations. These problems have long histories and multiple underlying causes, and they are unlikely to be amenable to rapid, simple fixes. We have also highlighted that much spoken communication is subtle, fast-paced and situated. Thus, unsafe communication can be due to the wrong tone of voice, dismissive body language, or a lack of interest between two people, as well as about specific items of information being missed, or the disorder in the way these items are presented.

We have reviewed examples of both good and poor practice. We have given more space to the latter, which illustrate both individual human failure and (in some cases) a wider culture in which ineffective, inappropriate and inattentive ways of communicating have become normalised. However, it is worth highlighting that in the millions of encounters involving spoken communication that occur in the NHS every day, a combination of human initiative, compassion and commitment often allow staff to overcome the time pressures, practical constraints and conflicting demands of a busy and fast-moving care environment. We have confirmed that spoken communication is a critical but under-used, under-appreciated and under-studied resource for ensuring that care is safe and effective. We must ensure that we learn from good practice, examining why it so often goes well and considering how can we replicate it (as well as focusing on the less common situations where something goes wrong).

The task we now face is bringing NHS staff up to speed with the increasingly challenging communication demands of an ever-more complex patient population and healthcare system. This means, besides prescribing what to say and how to say it, optimising the environment in which spoken communication takes place and involving staff in learning and training opportunities which more effectively enable them to use the spoken word (with patients and with one another) in a way that maximises the provision of safe and high quality care. Novel approaches to strengthening communication are now changing the way staff are trained and supported. The next phase of this work will clarify such approaches and propose how they might be applied across the NHS.

A call for a new paradigm in spoken communication

Taking inspiration from the literature on complex adaptive systems (Fraser and Greenhalgh 2001), we believe that it would be a mistake to pursue overly mechanistic or universal solutions to address the challenges of spoken communication. Rather, we believe the next stage of this work, to develop interventions, should attend to three linked tensions that have emerged in the work undertaken to date. These tensions cannot be eliminated; rather, they highlight the ongoing, contextual judgements that need to be made when seeking to assure patient safety through spoken communication.

There is a tension, for example, between the ideal communication situation described in Challenge 1 (page 6) and the actual situations in which spoken communication happens in the NHS, which require staff to be navigate through and respond to local problems using situational awareness and creativity. There is also a tension between good communication as narrowly defined (the exchange of precise, accurate and relevant information) and a broader definition of good communication (a social, emotional and cultural act that requires situational awareness, emotional engagement and

reflection). Finally, there is a tension between a structured and standardised approach to improving communication (supported by tools, technologies and checklists) and an approach which celebrates and supports the adaptiveness and intuition of human agents (whose responses to particular local challenges may rightly be unique).

To introduce this new paradigm, action will be needed at multiple levels and from diverse stakeholders. As we consider the next stages of this work to improve spoken communication, we intend to think through how we can promote and support action from number of groups as follows

First, *NHS staff* (both clinical and non-clinical) should be supported to know what good practice in spoken communication looks like and should strive to achieve this, recognising that much effective communication is adaptive rather than scripted. In the next phase of this work, we will consider the development of specific descriptors and guidance regarding communicative practices and styles. Those could build on existing good practice around the narrow (message-related) elements of communication and consider how these may be augmented by attention to the interpersonal nuances and wider social, professional and organisational context of words that are spoken.

Second, *people who train and develop NHS staff*, including both undergraduates and those in practice, should be supported to ensure that the teaching of spoken communication is pedagogically sound and reflects an up-to-date evidence base. The findings from our dataset strongly support the need to extend the existing curriculum and align with a new pedagogy of healthcare communication that addresses not just knowledge transfer but also the interpersonal and social context of speech and interaction and the impact this has on patient safety. This will almost certainly mean only a limited amount of didactic classroom learning (focusing on abstracted situations and behaviourist responses) and greater use of methods such as bedside teaching with real patients and realistic simulation (both of which can allow real-life experimentation and fast feedback). The questions for educators might be phrased thus: What strategies will enable clinicians to become more communicatively adept, respectful, trusting and committed to ensure the safety of their patients? How can we support them to respond appropriately and adaptively to unique and emerging situations that may require complex deliberations and negotiations? In the next phase of this work, we will consider more detailed recommendations for teaching spoken communication to NHS clinicians and non-clinicians.

Third, we will explore where responsibility for identifying consistently poor communicators who may put patient safety at risk should sit and who would provide support to poor communicators to improve (or, in very rare cases, stop them from practising). Relevant organisations could include employers and those responsible for the *licensing, fitness to practice and professional indemnity of NHS staff*. We anticipate that bodies such as the General Medical Council, Nursing and Midwifery Council, Royal Colleges and defence societies will need to be engaged and bought in to the new paradigm of spoken communication outlined above if we are to address this challenge.

Fourth, *leaders and managers of NHS organisations*, who create and maintain the environment in which NHS care is delivered, have a responsibility to develop the preconditions for effective spoken communication that assures patient safety. They must, for example, take steps to ensure as much privacy as possible; reduce noise and interruptions; provide access to interpreters and advocates; and support and reward good practice. Creativity should be encouraged and front line staff should be empowered and resourced to produce local approaches to achieving system-wide safety goals. In addition, NHS leaders should actively drive the cultural changes needed to support the kind of adaptive, flexible learning and reflective practice implied by the new pedagogy of context-sensitive healthcare communication. Whilst such cultural change is not easy (and will not occur overnight), it aligns with best practice on reducing and learning from significant events through a culture that encourages organisational learning (Iedema et al 2013, Speroff et al 2010, Department of Health

2015). Efforts should be made to encourage all people who work in the NHS to be aware of their own communication styles and tendencies and to reflect on their own communication processes on a routine basis (not just in response to patient safety incidents).

Fifth, *NHS patients and their carers*, who have a right to clear, appropriate and respectful spoken communication, also have a responsibility (insofar as they are able) to convey their concerns, expectations and information needs and whether they have understood what has been said to them. In the next phase of this work, we will be considering how best to support patients and carers to do this effectively and confidently, as well as reviewing what tools and resources (such as priority lists or structured tools) are available to help them and considering whether any additional ones are needed.

Sixth, *advocates for vulnerable and special-needs groups* have both a responsibility and a mandate to convey the perspective and needs of particular individuals and groups. They, and the groups they represent, have a right to be heard and to help shape NHS services to meet an increasingly diverse set of needs in an ageing and multi-cultural society. In the next phase of this work, we will seek to involve advocacy groups in the paradigm shift we believe is needed and in developing specific interventions where appropriate. One such intervention could be the 'communication passport', tailored for different groups and conditions, which outlines the individual's particular communication challenges and ways in which staff might communicate with them.

Finally, we believe *national policymakers* should work to support the development of the new paradigm for safety-relevant communication by identifying existing evidence-based interventions and, where necessary, developing new policy, guidelines, training and resources. They should make these widely accessible and ensure that messages from other NHS arms-length bodies and professional regulators acknowledge the new paradigm. As part of the next phase of this work the use of system levers to bring about the changes outlined in this document should be explored.

Conclusion

This report has summarised the first phase of a programme of work sponsored by NHS Improvement whose goal was to understand the challenges of spoken communication in the NHS with a view to (in a subsequent piece of work) informing the development, implementation and evaluation of interventions. We have confirmed that spoken communication between two or more people can be safely-critical. Notwithstanding the many examples of good practice we uncovered, there is much scope for improvement. At this stage, we caution against jumping to simplistic or formulaic solutions. Rather, we propose that the first step towards developing systematic approaches to improving spoken communication across the NHS is to appreciate the richness, complexity and social embeddedness of the words we exchange.

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Appendix: Membership of Patient Safety Initiative Group

Name	Title / Organisation	Sector
Professor Trisha Greenhalgh (chair)	Professor of Primary Care Health Sciences University of Oxford	Academic / Clinical (medicine)
Ms Joan Russell (initiative lead)	Head of Patient Safety, Policy and Partnerships NHS Improvement	Policy
Mr Hassan Ahmed	Patient Safety Team Co-ordinator NHS Improvement	Secretariat
Dr John Alexander	Royal College of Paediatricians and Child Health	Clinical (medicine)
Ms Khudeja Amer-Sharif	Patient Representative, NHS Improvement	Patients / citizens
Dr Paul Gardner	General Practitioner, Shropshire; ex-pharmacist and current member of National Patient Safety Response Advisory Panel (NPSRAP)	Clinical (medicine, pharmacy)
Professor Rick Iedema	Director, Centre for Team-based Practice & Learning in Health Care, King's College London	Academic
Dr Mark Juniper	Consultant in Respiratory and Intensive Care Medicine and Clinical Lead for Quality Great Western Hospital, Swindon	Clinical (medicine)
Professor Rebecca Lawton	Head, Bradford Institute for Health Research Bradford Royal Infirmary	Academic
Professor Ravi Majahan	Professor of Anaesthesia and Critical Care University of Nottingham and Vice President, Royal College of Anaesthetists	Academic / Clinical (medicine)
Ms Priscilla McGuire	Patient Representative, NHS Improvement Lay Member for Public and Patient Involvement Greater Huddersfield CCG Lay Member Joint Committee of Clinical Commissioning Groups, South Yorkshire & Bassetlaw Lay assessor, Royal College of Physicians	Patients / citizens
Ms Diane Parsons	Patient Safety Team Co-ordinator NHS Improvement	Secretariat
Professor Celia Roberts	Professor Emerita of Applied Linguistics Centre for Language, Discourse and Communication King's College London	Academic
Mr Wayne Robson	Patient Safety Lead, Clinical Review NHS Improvement	Policy
Professor Stephen Timmons	Professor of Health Services Management Centre for Health Innovation, Leadership and Learning, University Business School University of Nottingham	Academic
Ms Lorna Wilkinson	Director of Nursing Salisbury NHS Foundation Trust	Clinical (nursing) / Management