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Submitted to Learning from People about Things That Go Wrong in the NHS (Plain English)
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Introduction

In this survey, are you telling us about your own care, or someone else's?

The NHS care of a friend, family member or someone I look after

In general, how do you feel about the NHS services you use?

Ranking on NHS care - Please select one option:
Not good or bad

Roughly how often do you/the person you care for use NHS funded services? This could be seeing or speaking to a doctor, nurse or dentist, having a hospital appointment or stay, or using any other NHS-funded services.

A few times a year

Have you ever heard the words a “patient safety incident"?

Yes

We want to know how much people know about safety in the NHS. What do you think a “patient safety incident” means? (Tick as many as you want).

Slipping on a wet floor in a hospital (sometimes called “health and safety”)., Something that goes wrong when getting treatment, like being given the wrong medicine., Side effects of treatment.

Other -:

In NHS England, a "patient safety incident" means something that goes wrong, like being given the wrong medicine.Which words make this easier to understand?

Things that go wrong with care

Other -:

Have you heard of any of these before? (Tick as many as you want).

PALS (Patient Advice and Liaison Services), Patient Experience Team, The National Reporting and Learning System (NRLS), The Learn from Patient Safety Events (LFPSE) service, PHSO (Public Health Services Ombudsman), Charities which helps people when things go wrong (such as the Patients Association, Healthwatch, Care Opinion)

Learning from Patient Safety Events

Has something ever gone wrong in your healthcare, or the care of your friend/family member, that made your or their health worse?

Yes

Using an online service to report the incident

Would you use a website like this?

I don't know

Why?:

Healthwatch Birmingham believes that it is essential to provide a variety of ways for people to report incidents and complaints about healthcare services. While technology can be a valuable tool for this purpose as it can be done anywhere with an internet connection, it is important to recognize that it can also lead to health inequalities, as not everyone has access to the internet or digital platforms or has the necessary skills to use them. This is particularly true for people with sensory disabilities or those for whom English is not their first language. NHS Digital reports that one in ten people in England lacks basic digital skills and nearly six million people have never used the internet. Therefore, any decision to use a digital approach to learning about things that go wrong in healthcare must carefully consider the needs of digitally excluded individuals. Below are some of the feedback obtained from different users:

"Most of the Somali community you can say are uneducated about using digital services. Because they learn in the Somali language to use the phone of

the olden days. They don't know how to use these smartphones. These are the barriers they are getting in terms of accessing health services, social services and COVID-19 services."

"Since the lockdown happened, the GPs and NHS got a good excuse not to do what they need to do. For example, at my GP, if am ill, I have to go on the website, fill in a form about my illness and diagnosis, so many questions you have to answer and that takes 20 minutes. Then you have to write in 100 words what is wrong with you and describe your symptoms. A couple of days ago, we needed an appointment for my wife who needed a referral to Queen Elizabeth that was scheduled before the lockdown. The receptionist redirected me to the website. I had to tell the receptionist that my wife couldn't fill the form because she does not have good English. The receptionist said they did these forms to make it convenient for the doctors. I said 'Are you kidding, you are making it convenient and comfortable for the doctor? What about the people who are sick, who make it comfortable for them?' But she wouldn't budge. We just had to go onto the form and did the best we could. My wife is not a doctor and I'm not a doctor, so we did what we could. So, what hit me is, what about the people for whom English is not their first language? Some of them don't even have internet at home and do not even write in English. So, we are becoming since the lockdown a digital community and we consider that everyone in UK has access to computers, phone or internet. Even those that do have access are only looking at the pictures on the internet, they can't really read English or write in English."

Patients involved in a safety incident

When something went wrong in your care, what did you do next?

I wanted to tell NHS staff about it, but did not know how to.

Why?

Reason:

As a local Healthwatch, people contact us when they don't know how to make a complaint or they need assistance on how to make a complaint. People also contact us when they haven't got a satisfactory response to their complaints.

How did you feed this back to the NHS? (tick all that apply)

I told the staff straight away, I told the staff later on (including by letter or email), I made a complaint, I spoke to a charity that helps people when things go wrong

Other:

Final comments

What else could the NHS do to get better at learning from mistakes?

suggestions:

Learning from People about Things That Go Wrong in the NHS
Healthwatch Birmingham welcomes the opportunity to respond to NHS England's consultation on finding out how people would choose to tell things that go wrong in healthcare so as to help in designing a new online service to make care better. We are interested in improving access to health and social care through the feedback gathered from people across varying demographics.
Healthcare safety is a universal responsibility that has been emphasized for many years. The NHS provides excellent care to most patients, but serious mistakes sometimes happen. These mistakes can have devastating consequences for the patients and their families, as well as the staff involved. It is important to learn from these mistakes to improve the quality of care and maintain public trust in the NHS.
Patient Safety Incidents
According to NHS England, Patient safety incidents are any unintended or unexpected incident which could have, or did, lead to harm for one or more patient's receiving healthcare. We recognise many of the issues from our own engagement with the public. Patient safety incidents have been an issue that we are increasingly hearing about since the pandemic with many calling Healthwatch Birmingham and Healthwatch Solihull for support for their safety. As a local Healthwatch, people contact us when they haven't got a satisfactory response to their complaints, don't know how to make a complaint or they need assistance on how to make a complaint. People have also told us about the safety practices that are unsafe for both staff and patients, long wait for surgery which caused permanent disability, side effects of treatment, data protection issues and complaints not being dealt with appropriately. Below is some of the feedback we receive.
"The floor is filthy, debris and blood. Cubicles are being shared, again blood and clinical waste on floor, bins overflowing. How is the Trust allowed to get away with this? Why hasn't the Health & Safety executive stepped in and closed this place down? It is not fit or safe for staff or patients".
"I waited for nearly a year since I reported my sensory and loss of function in my hands to my GP, who immediately referred me to ROH. However, despite several internal and external escalations including PALS, GP I was seen way past the National NHS standards past 18 weeks (in fact I waited exactly around 7 months for surgery) by the time which my disability has now become permanent and lifelong. I've got to live with it and totally affects my quality of life".
"I was shocked and appalled at the way my dear Mum and other patients were treated at the hospital (name redacted) . I know that if she had not been admitted she would still be alive today. The doctor that very roughly examined her I believe caused the injury that led to her death".
"The individual is not happy with the care provided to her mother. "Currently dealing with the consequences of errors in my 91-year-olds mothers care for glaucoma which has resulted in her being registered as partially sighted and is life changing for her and myself. Would appreciate some guidance with my complaint and the process."
Digitalisation of incident reporting
Healthwatch Birmingham believes that it is essential to provide a variety of ways for people to report incidents and complaints about healthcare services. While technology can be a valuable tool for this purpose as it can be done anywhere with an internet connection, it is important to recognize that it can

also lead to health inequalities, as not everyone has access to the internet or digital platforms or has the necessary skills to use them. This is particularly true for people with sensory disabilities or those for whom English is not their first language. NHS Digital reports that one in ten people in England lacks basic digital skills and nearly six million people have never used the internet. Therefore, any decision to use a digital approach to learning about things that go wrong in healthcare must carefully consider the needs of digitally excluded individuals. Below are some of the feedback obtained from different users:

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Conclusion

Based on the feedback Healthwatch Birmingham has received from service users concerning safety issues, we highlight the below:

- Ensure that digital incident reporting and complaints logging systems are accessible to people with sensory disabilities. This can be done by providing text-to-speech and speech-to-text features, as well as accessible screen layouts and navigation.
- Provide support for people whose first language is not English by providing translation services and culturally appropriate support materials.
- Make it easy for people to report incidents and complaints without having to use a digital device. This can be done by providing phone numbers and drop-off boxes for paper-based incident reports and complaints.
- Provide timely and informative feedback to people on their incident reports and complaints. It should also include information about the actions that have been taken or will be taken in response to the incident report or complaint.
- The organisation should prioritise learning from mistakes and improving services being offered. When something goes wrong, a thorough review or investigation should be conducted which will involve all relevant stakeholders, including staff, partner organizations, and service users.
- Provide support to people who have experienced a safety incident or who have made a complaint. This support can be provided through phone calls, emails, or in-person meetings.

We believe that a focus on the above will enable NHS organizations to ensure that their digital incident reporting and complaints logging systems are accessible, effective, and supportive of all patients and staff. It is our wish to see further improvements in this area.

If you don't mind us asking you more questions about this in the future, please tell us your email address.

Email:
chipilirok@healthwatchbirmingham.co.uk

Diversity and Inclusion Questions

Which best describes you?

Not Answered

Is this the same as your sex when you were born?

Not Answered

What is your sexual orientation?

Not Answered

Other sexual orientation:

What is your age range?

Not Answered

What is your ethnicity?

Not Answered

Do you consider yourself to have a disability?

Not Answered

Do you belong to any of these groups? (Tick as many as you want)