Evaluation of the impact of conflict management training.

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Evaluation of the Impact of Conflict Management Training

Report prepared for Children's Hospices Across Scotland

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EXECUTIVE SUMMARY

The conflict management training has positively impacted on attendees.

Headline outcomes:

1. Attendance at the training drove a very significant increase in confidence in managing conflict (from 8.3% to 85.7%).
2. Respondents are now disseminating what they have learned in the training to other colleagues.

Other positive outcomes:

3. Respondents are now more familiar with the language of conflict resolution.
4. Respondents have de-personalised their approaches to resolving or de-escalating conflicts in order to focus on the practical implementation of approaches to resolution.
5. There is evidence of adoption of a mediation style in conflict resolution.
6. There is evidence of impact and benefit to parents as clinicians who are more confident are also better able to manage conflict and support families.
7. There is evidence of benefit to clinicians as their increased confidence helps them to support colleagues.

One recommendation can be drawn from the data:

1. A very wide range of sources of support and advice already exist, but these should be shared more widely with colleagues working in this space, to support them further. **Working collaboratively, CHAS, MMF and RGU should develop a resource kit which is widely available online, to support clinicians.**

INTRODUCTION

Aim

The aim of this project is to evaluate the impact of conflict management training delivered for Children's Hospices Across Scotland (CHAS) by The Medical Mediation Foundation (MMF - The Medical Mediation Foundation | Resolving conflicts in health and social care). The project is co-funded by CHAS and Robert Gordon University.

Scope

MMF were contracted by CHAS to deliver structured training on conflict management for clinicians working with children with a life-shortening condition and their families. The first cohort commenced June 2024, and the second cohort commenced November 2024. This report presents the evaluation of the impact of that training on clinicians' recognition and understanding of conflict with families and how those conflicts can be managed effectively, de-escalated or resolved.

Approach

In order to assess the impact of the training on their practice, three surveys were designed. Each cohort were identified by CHAS (by virtue of their registration to attend the training). CHAS sent out an explanatory email and participant information sheets to all those in each cohort who had registered to attend, and gave them an anonymised individual code and a link to the initial survey. Those attendees who consented to participate then completed the survey, identifying themselves only by their anonymised code. This initial survey was completed prior to their attendance at the training session, to give a baseline of their understanding of, and approaches to conflict management. Questions focused on the number of instances of conflict clinicians had experienced, the approaches they used to seek resolution, their confidence in managing those conflicts, and who they would approach for advice or support. On completion of the training, CHAS sent out a second explanatory email, the same anonymised code and link to the post-training evaluation survey. This second survey focussed on whether/how their approaches to resolving conflict had changed as a result of the training, and whether/how they planned to alter their practice in the future. CHAS then sent a final explanatory email, the same anonymised code and link to a 6-month follow-up survey which was designed to capture their understanding and experience of using the skills they had acquired over a period of time since the training took place, and the consequent impact on, or change in their practice. A 6 month interval was selected as participants needed a period of time during which they could reflect on how their understanding and skills had influenced their practice. The research was granted ethical approval by RGU's School Ethical Review Panel.

The appendices to this report set out each of the Google surveys in full, including all questions, diagrammatic data, and free-text responses. Throughout the report, selected quotations are included in the text where appropriate, in text boxes. Respondent codes are included. These are now fully anonymised as they have been recoded from the original code emailed to respondents by CHAS. As a result, only CHAS are aware of the original code and the identifying details of the respondent it relates to. CHAS did not share this with the researcher, who only saw the responses to the survey which use the code given rather than the respondent's name. The

researcher then assigned a new code to each respondent, and has not shared that with CHAS. This breaks the identifiable link between the respondents' names and email addresses, and the coding accessible to, and used by the researcher. The only identifying indicator which remains is that of the cohort to which they belonged; K indicates cohort 1 and E indicates cohort 2.

CONTEXT

Overview of the landscape

Supporting clinicians to proactively avoid differences of opinion or outright conflict with families, and identify and respond to conflict which has already developed is increasingly important as incidences of entrenched conflict continue to be played out in the English courts. In an analysis of reported cases, Lindsey *et al* track instances of conflict which have gone as far as the court in England and Wales from 2007 to 2022 which shows a total of 116 cases (Lindsey, 2024). The initial upsurge in numbers of reported cases comes in 2014 when the total number of reported cases that year was 12. In the 7 years prior to this, incidence of court cases sat at under 5 a year, with most years seeing a single reported case. From 2014 to 2022, a total of 104 cases were reported, which is an average of 11.5 per year, with 2021 and 2022 seeing the highest numbers, at 18 and 19 respectively (Lindsey, 2024, table 2). However, while this gives an indication of the scale of unresolved conflict escalating to court in England and Wales, the position in Scotland is somewhat different. There have been no litigated court disputes at time of writing, but research conducted in the Scottish context reveals that conflict between parents of children with a life-shortening conditions and clinicians does indeed happen, and work carried out across NHS Grampian, and funded by NHS Grampian Charity, shows that clinicians feel it is simply a matter of time before those conflicts become court cases (Sivers *et al.*, forthcoming). This is an important consideration for Scottish paediatric practice as, despite being set in NHS Grampian, participants in that study had significant experience of either (for families) receiving care in the children's hospitals in NHS Lothian or NHS Greater Glasgow and Clyde, or (for clinicians) having also worked in one or both of those hospitals.

The impact of unresolved disagreement that escalates to conflict and is litigated through the courts is well-documented. The report into disagreements in the care of critically ill children (Nuffield, 2023, p38-41) presents evidence gathered from interview data on the impact on the child themselves, and the emotional and psychological impact on all involved. The existing English reported cases show time and time again the scale of the negative burden which comes with taking a case to court, manifested in emotional and psychological costs, financial burden, abuse and death threats, and a toxic environment particularly on social media. These are exemplified in the cases of Charlie Gard (*Great Ormond Street Hospital v Yates & Ors* [2017] EWHC 972 (Fam)) and Alfie Evans (*Alder Hey Children's NHS Foundation Trust v Evans & Anor* [2018] EWHC 308 (Fam)), to highlight just two exemplars. Given the backdrop of the negative consequences for families and clinicians alike, it is important to assess how clinicians can play their part, alongside others, in developing their practice, and an approach to the care and treatment of children with life-shortening conditions that maximises the opportunities to avoid, or substantially mitigate the likelihood of conflict.

Response rates

The report is based on three separate surveys, one issued prior to the training date, one issued immediately afterwards, and one issued at 6 months to follow up. The pre-training survey received 48 responses, the post-training survey received 13 responses, and the 6-month follow-up received 14 responses. Qualitative research surveys carried out longitudinally always see an attrition rate in terms of numbers of responses as time goes on. In designing the survey, we followed standard ethical protocols and received ethics clearance from RGU, based on sending out an invite email plus one chasing email in respect of each survey, to each participant in the training. This standard method allows one opportunity to catch participants who have missed the original email, or who have not yet responded to it, but prevents any perception that the participant is being pressured into taking the voluntary opt-in surveys.

Data presentation

A number of key findings can be taken from the survey responses. These can be divided into quantitative and qualitative findings. The quantitative findings are presented first, to set out the incidences of conflict, and the data on self-reported confidence in managing conflict and knowledge of sources of advice and support. The report then presents the qualitative data from the long-form responses to questions about approaches to resolving or de-escalating conflict, and how those approaches change across the pre-training, post-training and 6-month follow-up surveys.

Throughout the quantitative data, percentages are presented to one decimal point and are therefore subject to rounding up or down as appropriate. This creates a tiny variation in the overall totals (where a strict total of all data in a particular question may not come to exactly 100%), but the use of a single decimal point makes for greater clarity and ease of assimilation of the picture presented by the data than running to two decimal points.

FINDINGS AND ANALYSIS – QUANTITATIVE DATA

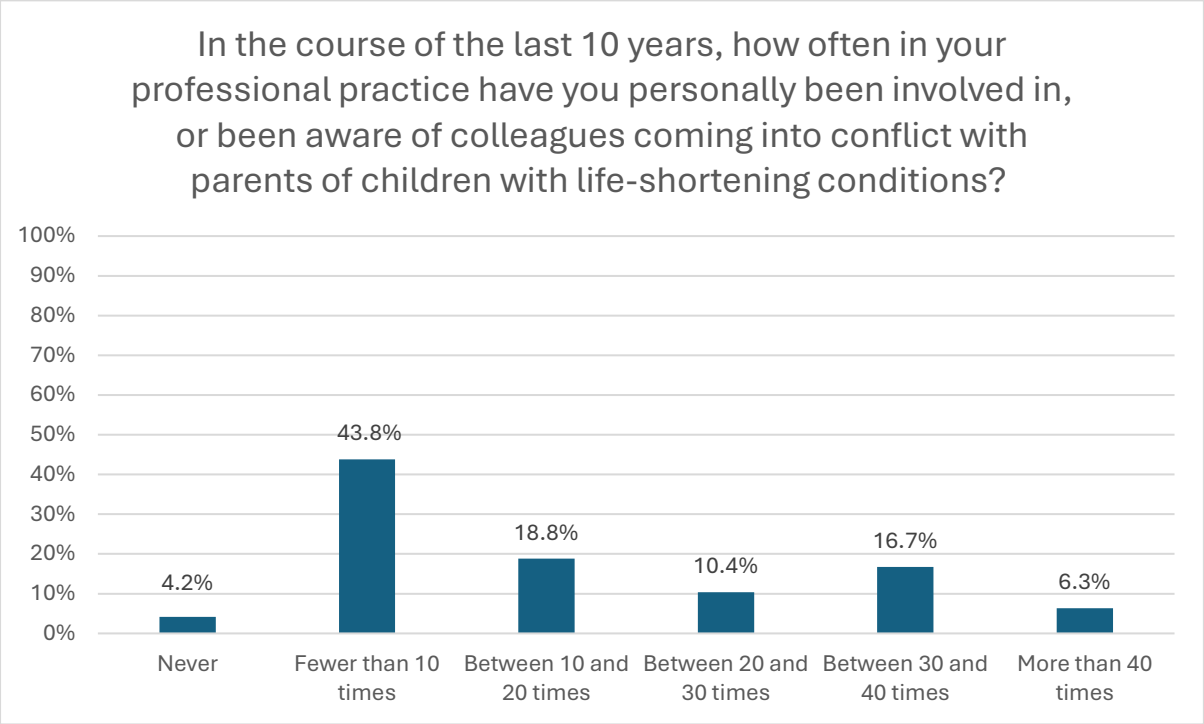
Scale of the problem facing clinicians

Respondents were asked to reflect on the last 10 years of their practice (the period from 2015 to date). This encompasses the period when Charlie Gard's case was in court in England (2016-2017) and the attendant high-profile media coverage and public and professional awareness of the issue of conflict over paediatric treatment. Across respondents, only 4.2% reported having zero experience, or not been aware of colleagues experiencing *either* conflict with parents *or* differences of opinion falling short of such conflict (Q2 and Q3, pre-training survey).

> **Over 95% of respondents had therefore either experienced conflict or differences of opinion for themselves or knew of colleagues who had experienced conflict or differences of opinion.**

Incidence of conflict between clinicians and parents

In the pre-training survey, respondents were asked how often in their professional practice they had personally been involved in or been aware of colleagues *coming into conflict* with parents of children with life-shortening conditions. The timeframe for this question was the last 10 years.



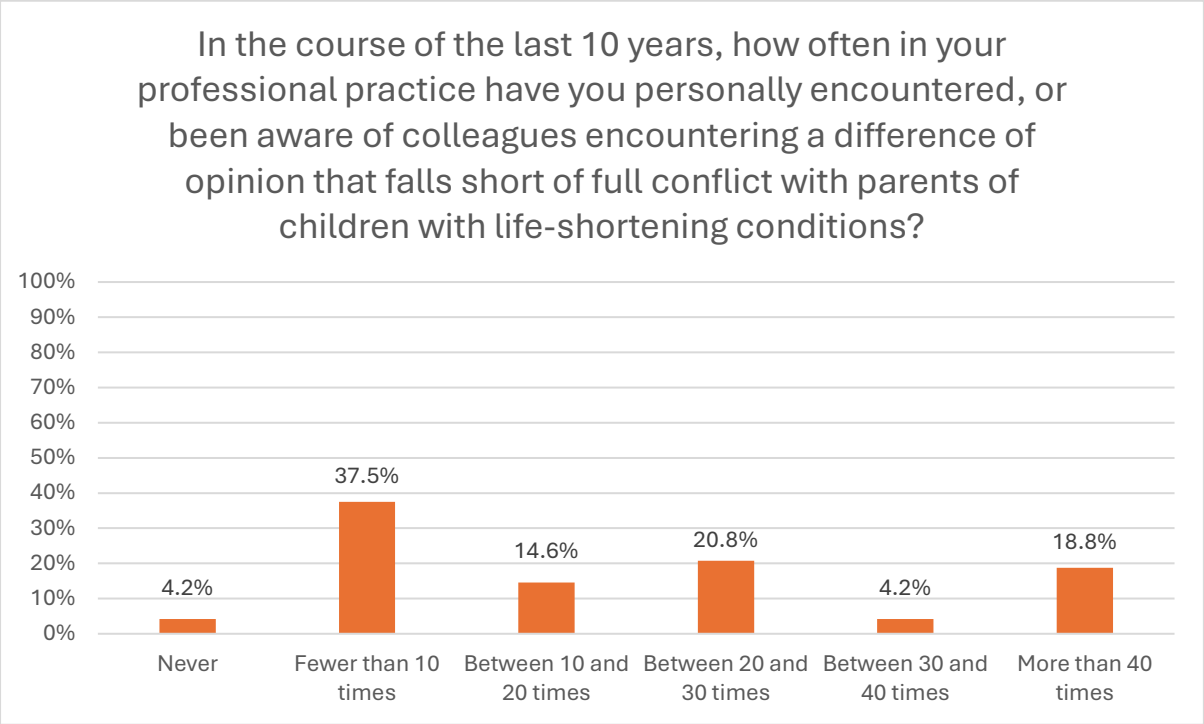
While very few of the respondents had encountered zero incidents of conflict (only 4.2%), almost half (43.8%) experienced an average of less than one incidence a year. Just over half (52.2%) experienced greater incidence of conflict (ranging from an average of once or twice a year to 4+ times a year), with 6.3% seeing the greatest number, averaging more than 4 incidences a year. Of those who indicated zero experience of conflict, one of these (E34), in response to being asked how they currently approach conflict, reported that they had only recently taken on a role that brought them into situations where this type of disagreement or conflict might arise.

> **96% respondents therefore had either personally experienced, or knew of colleagues who had experienced *conflict*, indicating that conflict with parents is a very common occurrence for those surveyed.**

Incidence of differences of opinion falling short of conflict between clinicians and parents

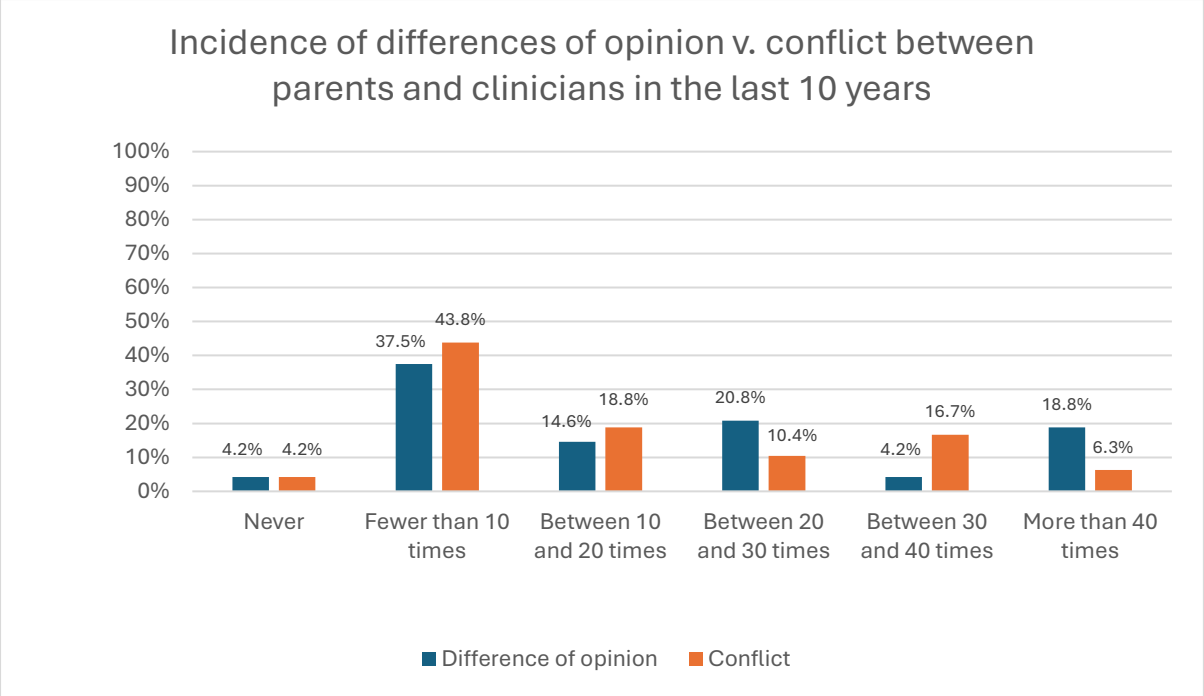
In the pre-training survey, respondents were asked how often in their professional practice they had personally been involved in or been aware of colleagues having *a difference of opinion*

which fell short of full conflict with parents of children with life-shortening conditions. The timeframe for this question was the last 10 years.



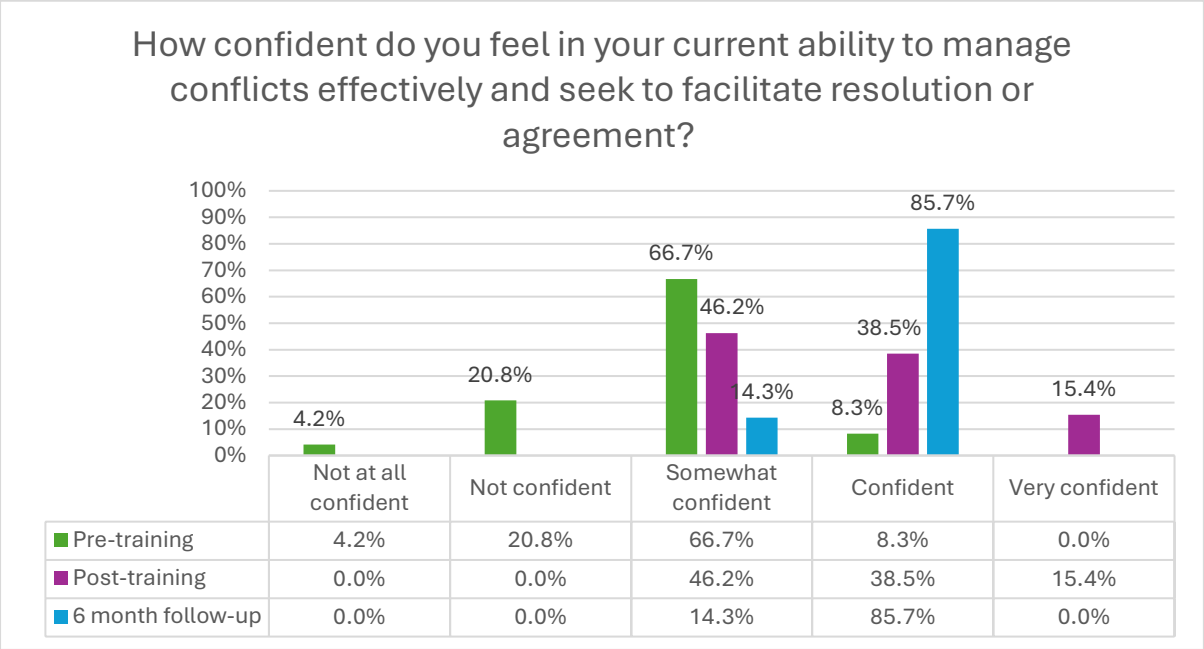
In line with the incidence of conflict, very few of the respondents had encountered zero incidents of a difference of opinion with parents (4.2%), just over a third (37.5%) experienced an average of one incidence a year. A little over half (58.4%) experienced greater incidence of a difference of opinion (ranging from an average of once or twice a year to 4+ times a year), with 18.8% of these respondents seeing the greatest number, averaging more than 4 incidences a year.

96% of respondents report experiencing or knowing of others who have experienced *differences of opinion* with parents and, again, shows that this too is a very common occurrence.



Comparing incidences of conflict with those of differences of opinion, 'never' scores the same in both categories, while 'fewer than 10' and '10-20' both record a slightly lower incidence of differences of opinion compared to incidences of conflict. However, incidences of differences of opinion were double the incidences of conflict in the '20-30' category and tripled in the 'more than 40' category. This and the two bar charts above give a baseline representation of respondents' experience of the incidence of conflict and differences of opinion between clinicians and parents and clearly shows that both exist within Scottish paediatric practice.

Confidence in managing conflict effectively and seeking to facilitate resolution or agreement



	Not at all confident	Not confident	Somewhat confident	Confident	Very confident
Pre-training	4.2%	20.8%	66.7%	8.3%	0.0%
Post-training	0.0%	0.0%	46.2%	38.5%	15.4%
6 month follow-up	0.0%	0.0%	14.3%	85.7%	0.0%

In the pre-training survey, respondents were asked to rate their *current* ability, prior to undertaking the MMF training. It therefore sets a baseline (shown in the green bars) for clinicians' confidence in this area based on the training they currently receive through their degree, in-house training and on-the-job learning through experience. The responses show that only 8.3% felt confident in their current ability, with the majority (66.7%) feeling 'somewhat confident' and the remaining 25% rating themselves as 'not confident' or 'not at all confident'.

> **This validates the decision to undertake the training, as 91.7% of respondents felt less than confident about handling an issue which 96% of them experience with at least some degree of regularity.**

In the post-training survey, respondents were asked to rate their confidence in their ability to deal with *any future conflict* they encountered, after undertaking the MMF training. It therefore shows any changes to their previously-recorded confidence in the immediate period following the training. These response reflect their reported perceptions of their future-readiness (shown in the purple bars). The responses show that 53.9% now felt either 'confident' or 'very confident' in their ability, with the remaining 46.2% feeling 'somewhat confident'.

> **This shows a significant improvement in confidence levels, with 0% of respondents indicating they have no confidence in their ability to manage conflict effectively.**

In the 6-month follow-up survey, they were asked how they *now* felt about their own confidence in their ability to deal with any future conflict they encountered, having had a period of 6 months in which to reflect on the training, and during which they may have had opportunities to put that training into practice (shown in the blue bars). In the 6 months after training, the vast majority of

respondents now felt 'confident' and the remaining 14.3% felt 'somewhat confident'. Again, no respondent classified themselves as 'not/not at all confident'.

> **In the 6-month survey, for the first time, the majority of respondents now sit in the 'confident' category.**

Looking at the 'somewhat confident' and 'confident' sections of the chart below, the trajectory over time, moving from the pre-training survey, to the post-training survey and then the 6-month follow-up, shows a clear improvement in confidence levels. The three bars in each section are almost mirror images of each other, with the percentages in the 'somewhat confident' section decreasing over time, while the numbers in the 6-month numbers increase over that same time period.

> **This clearly demonstrates that the effect of the training has been to move respondents into higher categories of confidence in their ability to manage conflict.**

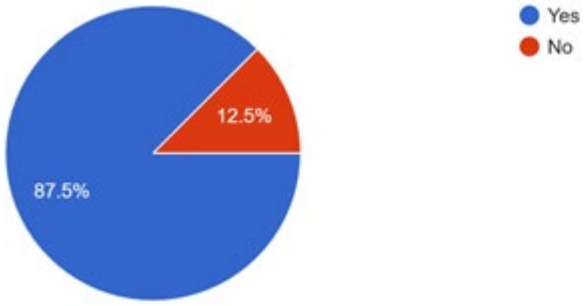
The chart shows a clear spike in the pre-training survey with the majority classifying themselves as only 'somewhat confident', while after 6 months, the majority classify themselves as 'confident'.

> **This represents a significant and positive outcome in terms of effecting a substantial increase in those who now report being 'confident' in managing conflict (from 8.3% to 85.7%).**

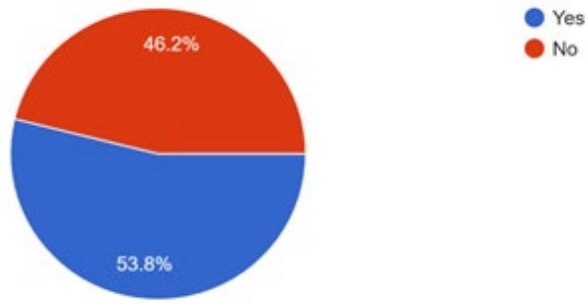
However, after 6 months, 0% report that they feel 'very confident' compared with 15.4% of respondents in the post-training survey. Further analysis of the data allows for tracking of those respondents who had previously rated themselves as 'very confident'. Respondent E34 had been 'confident' prior to undertaking the training, and increased their reported confidence to 'very confident' in the post-training survey. They did not return the 6-month follow-up survey. Respondent E37 had rated themselves as 'somewhat confident' pre-training, and increased to 'very confident' in the post-training survey, and again did not return the 6-month follow-up survey. Any attempt to analyse the drop in respondents who reported themselves as 'very confident' is therefore impossible, as there is no data on their level of confidence at the 6-month mark. It may be that, having achieved a very high level of confidence at the time of the post-training survey, they had continued at this level, but without the evidence of their 6-month responses, this is speculation. It could be argued that the differentiation between reporting oneself as 'confident' or 'very confident' is a fairly thin and subjective line. However, while it is disappointing to see 'very confident' disappear from the 6-month survey results, it could also be argued that having 85.7% of respondents reporting confidence in this area in the 6-month survey is at least as good as having 54% in total reporting themselves to be either 'confident' or 'very confident' in the post-training survey. The high spike in numbers reporting 'confidence' in the 6-month survey is a clear indication of a substantial improvement.

Knowing who to ask for advice and support

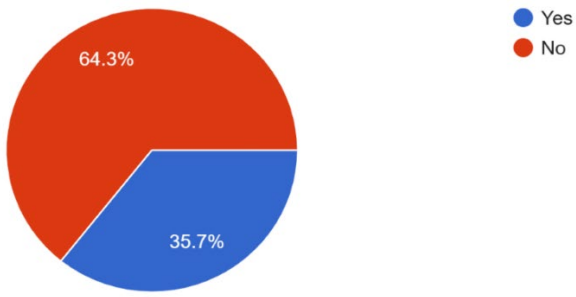
In the pre-training survey, respondents were asked if, when faced with conflict in their day-to-day practice, they knew who to ask for advice and support.



In the post-training survey, respondents were asked whether, when faced with conflicts *in the future*, they would now seek advice and support from a different role-holder, committee or organisation than previously.



In the 6-month follow-up survey, respondents were asked if, in the six months since they attended the training, they had needed to access advice and support in dealing with a conflict.



The vast majority of respondents indicated pre-training that they knew who to ask for advice and support.

This is encouraging and speaks positively of the levels of staff support and an environment that clearly signposts individuals/roles/committees etc. which are charged with, and able to offer that support.

Post-training, just over half of respondents would now approach someone different when faced with conflict in the future. The 6-month follow-up survey shows that 64.3% of respondents had not needed to access advice and support in dealing with a conflict. Correlating this with respondents' rating of their confidence levels at this 6-month stage, 85.7% of respondents now rated themselves as confident in dealing with conflict. This indicates that as confidence increases, the need to rely on advice and support decreases.

Further detail on *who* they identify as the source of this advice and support, and any changes across the surveys is reported under the qualitative findings below.

FINDINGS AND ANALYSIS: QUALITATIVE DATA

Approaches to resolving or de-escalating conflicts

Pre-training survey

In question 4 of the pre-training survey, respondents were asked to give free-text responses to the following question: "when you encounter conflicts between clinicians and parents, what approaches do you currently use to seek to resolve or de-escalate that conflict?" Respondents were given a free-text expanding box in which to do so, which generated a considerable amount of text. Looking at word frequency in responses can help to highlight where responses from participants coalesced around key words/terms/concepts. The word cloud below is generated from the responses to question 4, with the larger font indicating a greater frequency of that word in the responses.

All the words flagged here as the most commonly used in responses to this question are core terms one would expect to find. The most commonly used words here place a high emphasis on the *people* involved in conflicts, with private individuals and patients ('family' / 'parents' / 'child') as the dominant phraseology, and work colleagues ('professionals') at a lower level of frequency. Given the strong element of human relationships involved in these conflicts, it is unsurprising that the individuals/roles featured highly.

> ***It is noticeable that respondents talked more about the families, parents and the child themselves, than they did about their colleagues/fellow clinicians.***

This suggests that their perception of conflict is more of a linear relationship which cycles to and fro on the same path (clinicians ⟷ parents/family) and takes less account of the interaction between the range of clinicians involved in the child's care both in terms of intra-professional conflict (clinician ⟷ clinician) and in terms of parents having multiple conflicts with different treating clinicians/teams (clinician A ⟷ parent ⟷ clinician B).

Beyond the words indicating human relationships or roles, 'conflict' is most emphasised, which is to be expected given the context. 'Understand/ing' and 'listen/ing' are both given significant emphasis, followed by 'time', 'concerns' and 'view'. At a slightly lower order of frequency come 'discussion', 'solution', 'care', 'explore', 'relationship', 'open', 'opinion', 'meeting', 'explain' and

'resolution'. These are followed by 'empathy', 'trusting', 'heard', 'space', 'encourage' and 'feeling'. At the lower end of frequency, we find words including 'communication', 'transparent', 'decision', 'difficult', 'wishes', 'supported', 'informed' and 'perception'. Other words, represented in the smallest font sizes, were used rarely.

These words can be grouped by reference to actions and emotions. Some words focus on actions to resolve conflict ('understanding', 'listening', 'discussion', 'solution', 'explore', 'meeting', 'explain', 'resolution' and 'opinion') which is reflective of the respondents' roles and responsibilities, and a focus on outcomes.

> I would listen and take on board what they are saying and feeling then try and de-escalate the situation. (E28)

> A listening approach, try and hear and understand their point of view. (E23, taking an approach that weaves three actions together)

> Listening to the families to understand where the conflict lies - what can we do to work through the conflict in a calm manner. (K18)

> Try to meet with parents and listen to what they are saying but not offer an opinion, then discuss with professionals. Encourage parents attendance at MDT even if there needs to be a professionals meeting first. Advocate for parents during a meeting and check their understanding. Ask hospice medical teams to return to families and continue to explore understanding until a family are sure of what they are hearing. (K10, taking a multi-faceted approach to actioning conflict resolution, encompassing themselves and colleagues)

> I explore the goal of care for the baby, child, young person and parents from a person-centred/family-centred approach trying to understand what is most important for all at that time. (K13, taking a more exploratory and holistic approach)

Other words focus on emotional responses to conflict ('concerns', 'relationship', 'open', 'empathy', 'trusting', 'heard', 'encourage', 'feeling' and 'supported') and are reflective of a broadly-adopted empathetic approach to families in conflict with clinicians.

> ***These words are often used in tandem with action-oriented words, combining an empathetic approach with an outcome-focused approach.***

It also indicates that, prior to training, respondents' perception of conflict is of something focused around the parents and children, and that conflict happens 'to' them and impacts 'on' them. The question asked respondents to consider conflicts between clinicians and parents and so allowed room for discussion of their own experiences as a clinician in conflict with

parents, and also of their experiences of seeing colleagues in conflict with parents. Across the range of responses to this question, the majority of respondents commented on their own experiences of direct conflict, but some commented on experiences of seeing colleagues in conflict with parents. The language used in these comments includes almost no emotional terminology in respect of the clinician's position in any conflict or acknowledgement of the emotional impact of conflict on themselves or their colleagues. This suggests that, pre-training, clinicians view their role in conflict as 'the fixer' – to sort it out and bring it to an end. This can be directly contrasted with respondent K10 in the post-training survey who twice commented that, after going through the training, they no longer focused on trying to 'fix' the problem.

> I would be honest and open with them and try a find a solution to the issue. (E28)

> I allow them time to voice their concerns, I try to listen carefully. (E06)

> Active listening, empathy, using teach back techniques - so I am able to understand the individual families [sic] feelings on the situation. (K03)

> Listening and empathy. (E03)

> At present, I offer the family the opportunity to chat and tell their story in the first instance. This allows me to develop an understanding of their situation/beliefs/hopes and fears for their child and their family. It's also useful to try [to] understand their experiences so far. My hope is that this approach gives the family a voice and makes them feel heard and promotes a good foundation for our relationship going forward, I believe it's important to show respect from the beginning. (K28)

> Establish a trusting relationship. Ascertain the families hopes and wishes. Establish what is achievable clinically. Support both clinicians and parents in understanding each others [sic] perspective to reach a shared understanding. (K15)

> I would discuss the situation with the team lead/senior charge nurse. I would also seek advice from other colleagues where necessary. I would try to ensure the parents felt heard and supported and that I was deemed a mutual [sic – possibly 'neutral'] party in the situation to enable a trusting relationship. (E18)

> Encourage professionals to be honest and transparent with families about their thoughts concerns and try to encourage respectful discussion. (E05)

Try to take a trauma informed approach to understand previous experiences and where reactions/behaviours may be coming from. Apologies for how the parent is feeling. (K27)

Validating their fears and feelings by reflecting these back to parents eg I'm sorry it has made you feel 'angry, annoyed, untrusting'. (K05)

It is interesting to note that 'communication', something which is often discussed in other literature and in training as a key mechanism to either defuse or escalate conflict (depending on the strength of those skills), is used so infrequently here. It appears only four times; twice as a comment on their current approach in general and twice with reference to what they had learned from the EC4H [Effective Communication for Healthcare] training. However, 'understand/ing' and 'listen/ing' both score very highly and it is likely that they are being used here to convey communication skills, rather than using the word 'communication' itself.

I think about my communication. How I am communicating with parents. I try not to put my opinion over. (E06)

Good, open and honest communication is always the basis of resolving conflict. (K18)

Post-training survey

In question 2 of the post-training survey, respondents were asked to give free-text responses to the following question: "when you encounter conflict between clinicians and parents *in the future*, what approaches do you plan to use to seek to resolve or de-escalate that conflict?" Respondents were given a free-text expanding box in which to do so. The word cloud below is generated from those responses, with the larger font indicating a greater frequency of that word in the responses.

Instead of word frequency indicating a high emphasis on the *people* involved in the resolution of conflicts, respondents used language here which is much more aligned to the *methods* of resolution or de-escalation.

> ***This indicates that participation in the training had focused respondents on measures they could use and approaches they could take, and in doing so, had de-personalised the context of conflict.***

'Parents' figures only once in the collated responses, which is a significant difference in frequency from the pre-training survey. 'Self' also only figures once. In contrast to the pre-training survey, the focus of the responses was more tightly framed around 'listening', 'information', 'conversation', 'actively' and 'cues', all of which were used most frequently. Words used in the next order of frequency include 'silence', 'language', 'communication',

'responsibilities', 'right', 'agreement' and 'break'. These words all highlight a focus on the process and practice of conflict resolution[1].

> ***This indicates that respondents had shifted their thinking, in the immediate period after attending the training, from a more expectable focus on who is involved in a dispute, to a focus on what to do to resolve it, and the practical measures they could adopt.***

Words used less frequently here include 'mediation' itself, but many of the other words used post-training are directly relevant to techniques and approaches that would be used as part of a mediation process ('cues', 'active listening', 'common goals', 'collaborative', 'relational', 'open questions' etc).

> ***This indicates that respondents have adopted a mediation style in resolving conflict and their responses delve into the specifics and detail of that style, rather than using its more descriptive title of 'mediation'.***

As well as evidencing shifts in thinking and the use of mediation-related terminology after they have attended the training, some respondents specifically reference the MMF training itself here (see E34 in direct terms, K16 for direct mention of 'mediation', and E27 and E34 discussing the 'framework'/'models').

Look for cues and triggers. (K08)

Active listening, the models provided by MMF - stage 1 conversations, stage 2 conversations (responsibilities agreement). (E34)

Discuss use of mediation. (K16)

Really listening to parents and demonstrating that I am doing so, encouraging others to do the same. Listening for cues. Try to establish common goal. Showing a genuineness in communication with the parent. (E05)

Stopping, actively listening, holding silence, responding not reacting. Establishing a relational, collaborative relationship, trauma informed language and approach, kindness to self. (K01)

Face head on, be less sensitive, take less personally, LISTEN. (K23)

[1] 'Shut' is an outlier here, appearing because of one response which emphasises the need to listen to parents by repeating the phrase 'shut up'.

I would be more inclined to start de-escalation before the escalation when the initial indicators start to appear as opposed for waiting until the point that communication is beginning to break down fully. I would also be more inclined to listen to all the information before trying to reach solutions. I would not be as resistant to escalating to the next stages of conflict management if it was the appropriate thing to do. (K09)

Address the conflict, listen, notice cues, paraphrase, pay attention to my language, don't get caught up in right and wrong and use a responsibilities agreement. 'Shut up, shut up, shut up!' (E37)

Use framework, open questions, actively listen. (E27)

A listening approach without expectation to 'fix' the problem. Facilitate time for the parent and the clinician to hear each other and share information without being defensive. Take a break if tensions are high. Sitting with silence. (K10)

6-month follow-up survey

In question 3 in the 6-month follow-up survey, respondents were asked to give free-text responses to describe how they had approached conflicts they had encountered in the 6-month period since they attended the training.

K19's response is a particularly powerful encapsulation of an approach to conflict that is informed by values and respect, allows for time and space, and prioritises understanding of the individual.

Hopefully with compassion, patience, and curiosity. (K19)

A number of respondents discuss not jumping in and proactively using silence as a key change in their approach. Addressing the fact that conflict had occurred, discussing it promptly and the value of an apology are also identified as key elements of their practice since they attended the training.

Both K03 and K13 felt that their approach and/or the skills they had used since the training had not changed, indicating that their existing practice (K13) or other training they had attended (K03) had equipped them to approach conflicts. While K03 felt that the Effective Communication for Healthcare training had given them the skills they needed, they also felt that the MMF training had been useful for clarifying that approach and providing a rationale for its use.

I believe I have mostly been using the skills/approaches that were taught on the course but this was through experience and skills from EC4H [Effective Communication for Healthcare programme]. However it did highlight the approach I was using and the rational for it. (K03)

My approach hasn't changed drastically. I feel I will always listen to parents and try to create the safe environment to talk openly about their fears and hopes. In conflicts about treatment management at end of life, I will always approach this from a goals of care concept. What is most important to you right now as a family and how can we work together to achieve this. (K13)

Allowed time for the family to talk, didn't jump into silences but instead let the silence play out. (K07)

After the conflict happened, I discussed with the parents after the incident in a timely manner that same day. We discussed the situation in detail. (E11)

I advised parents that I was sorry to hear that they felt this way that I would remove myself from their care and offered for the family to speak to management re areas of concern, by the end of the day when I went in to the child's room the parent immediately apologised and explained that she had been overwhelmed and unfortunately I got the brunt of her feelings. (K08)

6-month follow-up survey: changes in practice within the 6 months since the training

Respondents were asked in question 4 to describe how their approach to these conflicts had changed as a result of the training and the passage of the intervening 6 months. Responses reflected a strong focus on communication, use of language and active listening as the key skills which they employed in the months following the training. These are issues which respondents had also listed in the pre-training survey, but the emphasis here is on more nuanced skills. For example, in the pre-training survey, 'listening' was a commonly noted approach. In the (albeit smaller number of) responses at the 6-month mark, '*active* listening' and the use of probing questions to gather more information ('tell me more about that') feature more dominantly.

It has made me more aware of the language I might choose to use and that listening carefully with curiosity and compassion to what is being complained about is crucial. (K19)

I think the training emphasized the importance of active listening, reflecting/clarification and summarizing. (K03)

> The training gave me validation that the approach I adopt is sensitive yet honest and productive. The phrase 'tell me more about that' is always a helpful one to have in my back pocket. (K13)

6-month follow-up survey: planned approaches to any future conflicts where no conflicts had arisen in those 6 months

For those respondents who reported no incidence of conflict in the 6 months since the training, question 5 was re-phrased to ask them to consider how they now *planned* to approach any future conflicts. Responses here reflected a similarity in planned approach to those who had encountered conflict in the 6-month period after the training. It is worth noting therefore that participants' ideas of how they might approach conflict after they attend the training, and the reality of how they have actually approached conflict do not differ markedly. The focus is again largely around listening, particularly active listening, and stronger communication skills. There is also a focus on understanding different agendas and the drivers for conflict, which were not expressed directly in the responses from those who had experienced conflict in the previous 6 months. One respondent reported feeling confident enough, since the training, that they were able to deal with potential conflict before it escalated.

> Spending more time actively listening. Being more aware of the differences between health professionals [sic] agenda and the families. (K03)

> My approach before the training was probably to plan and prep my answers before going into a meeting. I would now think about options however would not plan responses but try to really listen more and respond to what I'm hearing rather than what I think I know. (K27)

> I would be more confident about saying less, listening more, acknowledging the other persons concerns and re-capping what I think they are saying and then attempt to find mutually acceptable way forward. (E30)

> I feel confident enough now to deal with conflict but feel i am better at dealing with problems before they reach the top of the iceberg. (E29)

> The training has enhanced my understanding of driving factors influencing conflict. I gained confidence in not seeking to give a " defensive" [sic] to complaint but rather exploring the feelings behind the complaint. (K15)

> I think I would listen to what is being said and slowly pick apart bits and then give the person time to talk. I would let them know that I am listening and hearing everything they are saying. I think after the training it has highlighted that time is important and to give the person my full attention. (E25)

I really appreciated the course reinforced with evidence that my preferred method of open and honesty and apologising for the system failures was the best way to manage conflict. The recognition and a trauma informed approach to establish the route cause. Acknowledging my own unconscious bias and naming those to allow for a more neutral conversation. the importance of silence and using it as a tool to really listen. (K09)

What I believe is really important is giving families the opportunity to feel listened to, to discuss and describe anything they need to and not to seek solutions. (K10)

6-month follow-up survey: situations where the training has caused a change in practice

Question 9 asked respondents to reflect on their day-to-day practice and whether the training had caused any changes to it. Listening, curiosity (as to the root cause of potential grievances), being prepared to have a difficult conversation and the value of silence all feature consistently through the responses.

Difficult to give direct example. I feel that by spending more time listening and clarifying gives a deeper understanding of the situation. The families value this. More awareness of non verbal behavior's [sic]. (K03)

More confident. (E30)

As above, this training aligns with other work and my personal growth around listening and providing clear and concise context/ boundaries. (K27)

In the general context of practice I am mindful of being more curious to families potential grievances and the root for those misgivings. In exploring this with families it can help them recognise that this at times is situational rather than a neglect of their care thus limiting the escalation to conflict. I have definitely developed my active listening skills. (K15)

More likely to have difficult conversations. (E03)

I feel more confident in talking things through with staff and identifying any problems before the [sic] reach conflict stage. (E29)

I have been in a situation during a difficult conversation that i made sure we moved from a busy room to find a quiet area. I made sure I didn't have an agenda of questions I thought I needed to ask. Instead I listened and then prompted questions from what was being said. I think time and listening is something I am much more aware of. (E25)

I appreciate how important silence is as a tool and I have been working on my own discomfort with this. Also trying to encourage to holistically at any issues that occur remembering that what may have caused a reaction is most likely not the route cause but an accumulation of factors. As with everything behaviour is communication and if we remove our own emotions and biases from a situation we are better placed to have effective conversation. It is also vital to have an awareness of how you are coming across to others. (K09)

In every conversations to be honest. I definitely remind myself that it is not my responsibility to fill a silence and often leaving the silence allows either the staff member or the family member to further elaborate on their experience. (K10)

<u>6-month follow-up survey: how changes in practice have impacted or benefited parents or other clinicians</u>

As a final question about respondents' own practice and the changes effected by the training, question 10 asked them to give their views on how those changes had translated into impact on or benefit to parents and clinicians. In some respects, this is the most important question and so all responses have been reproduced here, rather than a selection. The evidence here shows a number of important issues.

Respondents report greater appreciation of the need for an honest, consistent and considered approach (K27 and K07 – in both cases, the language used infers benefit here to both parents and clinician colleagues). Some respondents also directly recognise the benefit that has come from their own increased confidence (E03 and K08 in terms of their own confidence, E25 recognising that in has benefited them in their professional role, and also benefited colleagues and families as they are now more able to deal with these moments of conflict).

A further benefit to both clinicians and parents comes from the ability to explore issues and gain a deeper level of understanding, which then feeds into better planning of that individual's support needs. This is identified by K15 and K10. Alongside this, respondents report a greater awareness of their own biases and understanding of their temptation to defend service delivery (K15 and K09).

> **There is also evidence that respondents are disseminating the training/skills to colleagues through peer-to-peer engagement and role modelling.**

This engagement is evidenced either by virtue of working with and supporting colleagues (K07), because they have been asked to directly engage to support resolution of a conflict (K03), or because they are now able to model listening approaches which has allowed colleagues to recognise listening as a priority in developing trust (K15). This is also shown in E29's response to

the previous question (“I feel more confident in talking things through with staff and identifying any problems before the [sic] reach conflict stage”), embodying not only confidence in their own ability, but also confidence to take colleagues through the process and support them to handle conflict better.

I have been asked to directly support in situations where conflict has become apparent. (K03)

More willing to mediate between staff when required. (E30)

I have always thought of myself as very approachable however had been finding it more challenging within my leadership role to remain open and approachable but also to provide safe and effective guidance and boundaries. This training helped me to see the importance of honesty and consistency in approach and language rather than just a focus on 'being nice.' (K27)

I hopefully have a more consistent and considered approach to these situations which supports myself and supports those I am working with and for. (K07)

I have been able to model a listening approach to families whilst exploring their feelings whilst resisting the temptation to defend service or oppose their views. This has allowed clinicians to recognise the families [sic] needs to be heard as a priority for developing trust and reduce the progression to conflict. (K15)

Increased confidence. (E03)

I think it has benefitted me in my role as support worker but also it is of benefit to my colleagues and the families i am working with everyday. The training has given me more confidence in these moments. It is something i will continue to build on and take a little bit away both good and bad when in situations with conflict. (E25)

I have continued to work on my understanding checking with those that I have been involved in conflict with. I am trying to follow a more of a coaching methodology when working with others and ensure awareness of my own behaviour and unconscious bias. (K09)

I believe I get a deeper understanding of the staff member or family members thoughts and wishes or challenges. I can then better plan what support can be given and also negotiate how this is given and by whom. (K10)

I personally feel more confident, I feel that it has given me the confidence to approach difficult situations and express how I feel and what my intentions were. (K08)

Identifying those able to advise and support

Pre-training survey

Respondents identified a wide range of colleagues and others to whom they would go for support. Line managers, peers/colleagues, senior charge nurses and advanced nurse practitioners were the most commonly cited. Nursing or medical directors, service managers and clinical nurse managers were cited with some degree of frequency. All these roles are expectable sources of advice and support for those facing conflict situations. However, there was also a wide range of other individuals and services that were mentioned infrequently, often by one respondent only. These are: the family support team, area social work, internal social work team, the MDT, ethics committees, HR, legal, sibling support, community nurses, dieticians, 'colleagues who have a positive relationship with the family', Maternity and Neonatal Psychological Interventions (MNPI) services, Kindred, external coach and outside psychologist during clinical supervision. The inclusion of these individuals/organisations is interesting. Some respondents look to colleagues in roles designed to support the child and family, outside the direct clinical context (the family support team, and sibling support workers). Some look for support for colleagues whom they know to already have a positive relationship with the family. Some respondents have reached out to a wider range of their colleagues and peers (for example, social workers, community nurses or dieticians), with one respondent specifically explaining that they do this in order to get a holistic picture of the child's and family's situation. Others look for advice from in-house services and departments with roles in decision-making and conflict resolution (the MDT, ethics committees, MNPI services, HR and legal teams), while some look for support from external organisations or individuals (supervising psychologist, Kindred or an external coach).

> **This shows that a wide range of sources of support and advice are potentially available albeit that few respondents reported utilising them. This indicates that wider awareness of these sources of support and advice could be beneficial to those facing conflict. CHAS, MMF and RGU should therefore work collaboratively to develop a resource kit to support clinicians which is easily retrievable across multiple platforms, to minimise barriers to accessing the information and support.**

Post-training survey

Respondents were asked, immediately after the training, whether they would now approach a different individual or organisation for support and advice. The responses brought out a number of previously-unmentioned individuals, services and organisations. These are: Diana nurses, mediators, "a third party to talk through the situation [with]", "other organisations to further

support us" and the Quality and Care Assurance team. This indicates a recognition, post-training, that there are additional support and advice resources available, and that these respondents are now more aware of the opportunities to seek specialist paediatric advice (Diana nurses), conflict resolution professionals (mediators), formal quality assurance specialists, or open to simply talking and sharing their feelings and concerns with someone else in order to understand their situation more fully.

6-month follow-up survey

At the 6-month stage, respondents were asked who, after a period of time since the training during which their new skills and experiences of conflict had allowed their practice to develop, they would now ask for advice and support. Responses to this question showed almost no further changes in terms of where respondents go for advice and support. One respondent identified the risk team in respect of an SAER but the remaining respondents identified individuals or role holders who had already featured in the pre- and post-training responses. Response rates across the three surveys differ, with fewer respondents completing the post- and 6-month surveys (as is normal in qualitative research), so the ability to follow respondents through from one survey to the next is limited. 2 respondents can be tracked in this way. K08 and K10. Both are clinicians with significant experience of conflict (K08 = 30/40 incidents in the last 10 years, K10 = 40+ incidents in the last 10 years), and both have increased their confidence levels from 'somewhat confident' in the pre-training survey, to 'confident' at the 6-month mark. Across the three surveys, K08 moved from seeking support and advice from their manager, to the Nursing Director, and then to the service manager, showing a shift from seeking support at a operational level, to a more strategic executive level, and then returning to a lower level. K10 moved from looking to their peers and line manager, to QCAT and their line manager, and then just their line manager, showing a shift from a very localised level of their immediate peers and upline, to the team responsible for quality and care assurance, and then returning to their line manager. Both appear to have responded to the training by significantly escalating the seniority of the person/body they would look to for advice and support, and then scaled this back over the course of the following 6 months. Why they have done this is not possible to ascertain from the data. Given the frequency of incidents of conflict they both experience (3 to 4 times a year on average), the likelihood is that they have experienced conflict in the 6 months since the training.

However, what is more striking from the responses across all three surveys is that none of the respondents to the 6-month survey identify any further external sources of support and advice which they would draw on, or any of the wider range of colleagues evidenced in the first survey. The questions are phrased cumulatively, looking at who they approached pre-training, and whether that has changed since. Again, it is important to remember that respondent numbers decrease across the three surveys so the wide range of individuals and organisations reflected in the responses in the pre-training survey sets a baseline. Those who chose to respond to the post-training survey indicate they would go to some external sources: a mediator, other organisations, or unspecified third parties. In the 6-month follow-up survey, no respondents indicated they would go to external sources of advice and support, or indeed any of the wider colleague base who might provide that holistic picture of the child and family. It is unfortunate that those who responded to the pre-training survey and indicated they would look to a wider pool of colleagues, or that wider range of external organisations and individuals, did not respond to the later surveys. It is therefore hard to draw any conclusions from this, beyond an

assumption that, if it had been their practice to go to these sources of support before the training, they would continue to do so afterwards.

CONCLUSIONS AND RECOMMENDATIONS

Conclusions

The above analysis of the data collected from respondents has resulted in a **positive impact** on those who attended, and created a benefit to families in their interactions with clinicians, and to clinicians in their engagement with colleagues and with patients and families. As well as the positive outcomes from the training listed below, there is one resultant recommendation to further support improvements in practice. The first two outcomes are those with the greatest significance (the baseline increase in confidence and the evidence that those who have been trained as now sharing that knowledge with others) and are highlighted as such.

The outcomes are:

1. ***Reported increase in confidence:*** **attendance at the training drove a very significant increase in confidence in managing conflict, from 8.3% to 85.7%.**
2. ***Evidence of peer-to-peer dissemination*****: respondents report being able to disseminate what they have learned in the training to other colleagues, indicating that the skills and learning from the training are beginning to embed themselves both within the two cohorts who were trained, and also among their wider group of colleagues.**
3. *Familiarity with the language of conflict resolution*: attending the training allowed respondents to talk about, and describe how they would now approach conflict more fluently and in a more nuanced way, utilising more detailed descriptors and a greater range of terminology to describe the processes of mediation.
4. *De-personalising their approaches to resolving or de-escalating conflicts*: attending the training shifted respondents' from focusing largely on the people involved, and prioritising families, parents and children in their description of their approach, to also focusing on practical measures they could implement and methods they could adopt.
5. *Evidence of adoption of a mediation style in conflict resolution*: respondents demonstrate through their adoption of specific language that they have assimilated the training and applied it to their own approaches to their practice.
6. *Evidence of impact or benefit to parents*: respondents have a greater appreciation of the need for an honest, consistent and considered approach, they have increased in confidence and are better able to deal with instances of conflict, which supports families. They are better able to explore issues, gain deeper understanding and in turn make better plans to support individual (family) needs.
7. *Evidence of benefit to clinicians*: respondents have a greater appreciation of the need for an honest, consistent and considered approach, they have increased in confidence and are better able to deal with instances of conflict, which supports colleagues who are experiencing conflict. They are better able to explore issues, gain deeper understanding and in turn make better plans to support colleagues' needs.

Recommendation

1. That the wide range of support and advice services identified by individual respondents is collated and disseminated more broadly, to support clinicians. **CHAS, MMF and RGU should therefore work collaboratively to develop a resource kit to support clinicians which is easily retrievable across multiple platforms, to minimise barriers to accessing the information and support.**

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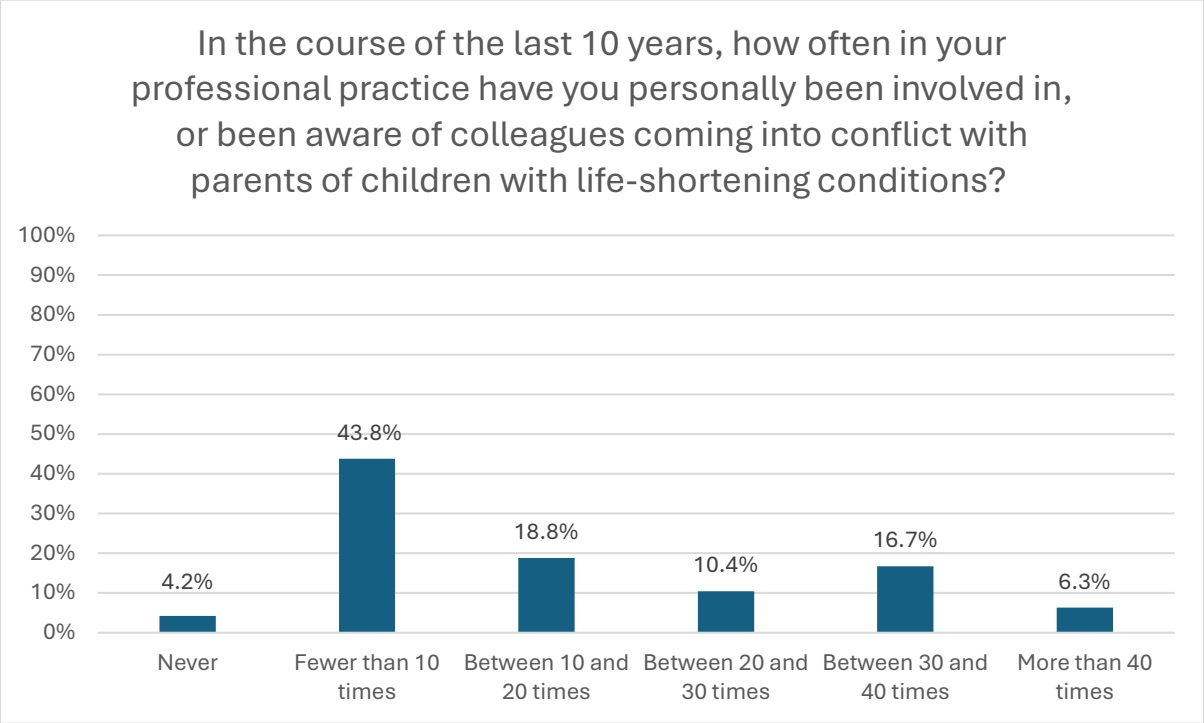
APPENDICES

Appendix A – Google survey data

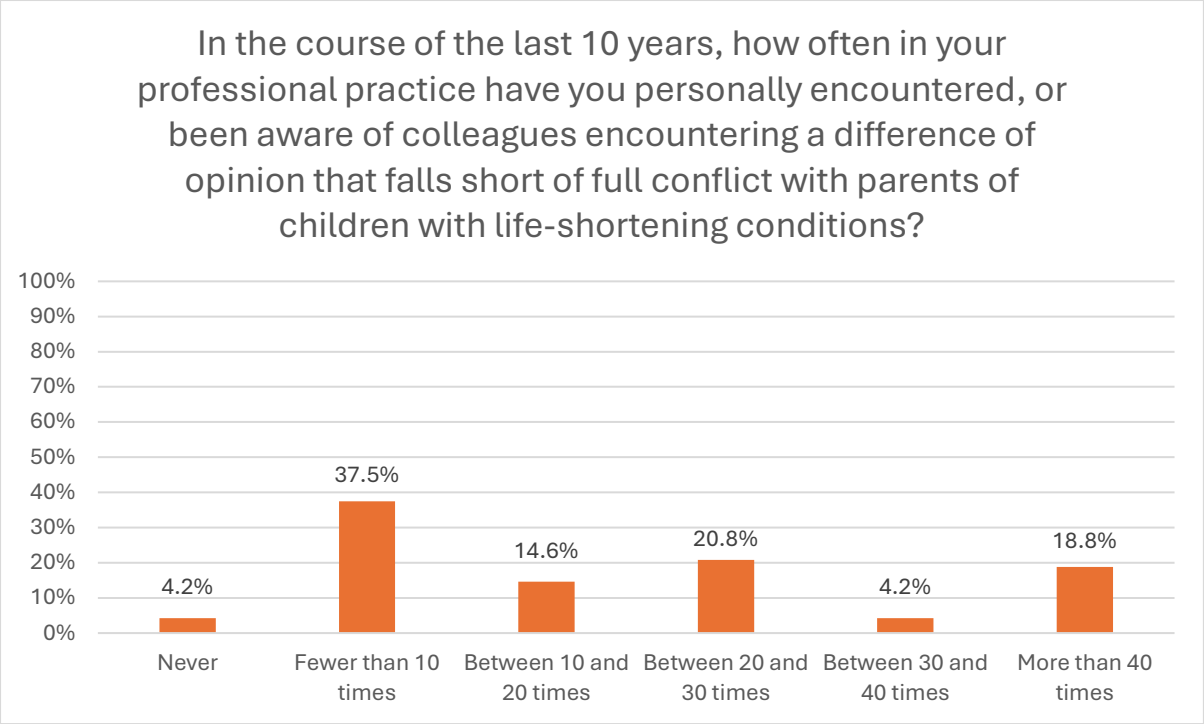
Responses - Evaluation of the impact of conflict management training on paediatric practice – pre-training evaluation survey

Q1 – participants entered their anonymous code, generated and given to them by CHAS in the participant information pack. Only CHAS know the personal identifiers for each participant. That code has since been replaced by the PI with a random generated code. This code can no longer be traced back to the individual.

Q2 – In the course of the last 10 years, how often in your professional practice have you personally been involved in, or been aware of colleagues coming into conflict with parents of children with life-shortening conditions?
48 responses



Q3 - In the course of the last 10 years, how often in your professional practice have you personally encountered, or been aware of colleagues encountering a difference of opinion that falls short of full conflict with parents of children with life-shortening conditions?
48 responses



Q4 – When you encounter conflicts between clinicians and parents, what approaches do you currently use to seek to resolve or de-escalate that conflict? (Please describe in the box below in as much detail as possible)
41 responses (anonymous respondent code included)

- I am new to the role in palliative care and have not previously worked in a role which brought me into such conflicts. E34
- I would listen and take on board what they are saying and feeling then try and de-escalate the situation. I would be honest and open with them and try a find a solution to the issue. E28
- At present, I offer the family the opportunity to chat and tell their story in the first instance. This allows me to develop an understanding of their situation/beliefs/hopes and fears for their child and their family. It's also useful to try understand their experiences so far. My hope is that this approach gives the family a voice and makes them feel heard, and promotes a good foundation for our relationship going forward, I believe it's important to show respect from the beginning. K28
- Listen to both parties and mediate between the two. E02
- To try and de-escalate the issue and allow them to talk. E07

- Using proactive approaches to support families in a way that helps reduced the chance of conflict arising, giving families the time and space they need to express themselves in a way they feel appropriate, addressing conflict in a way that is not threatening or patronising. E14
- Listen and try to gain an understanding of the reason as often this is not the initial problem/concern/complaint raised. Try to take a trauma informed approach to understand previous experiences and where reactions/behaviours may be coming from. Apologies for how the parent is feeling. K27
- I think about my communication. How I am communicating with parents. I try not to put my opinion over. I allow the parent to ask as many questions as they want. I allow them time to voice their concerns, I try to listen carefully. I suppose I try to go between parents and clinicians and explain what concerns/ what is important to both. I suppose I am trying to bring both together so clinicians and parents both agree on a child's care, but sometimes this is difficult to achieve. E06
- Discuss my concerns with peers. Contact experts in the field where appropriate. Arrange a face to face meeting outwith other clinical commitments. In the last 3 years online discussion is possible and has been used if family cannot meet in person but I would prefer face to face contact. Allow sufficient time, allow family to give their point of view, discuss their concerns. Offer second opinion if family wish. K14
- Engaging the help of a colleague, ideally someone trusted by the family. K24
- Use ec4h [Effective Communication for Healthcare programme] training. K21
- A listening approach, try and hear and understand their point of view. E23
- Attempt to create open discussion in a calm environment, attempting to use an open approach, listen and understand the families view, offer as much information on the clinicians view as possible to find common ground to work with. E30
- Listen to what parents are saying, meet as a team to discuss, the go back to parents. Have done this in a comfortable area away from the child, and have had key worker or a key member of the team that has a good relationship with the family present. Have had discussion with external professionals for their opinion and on one occasion had the meeting with external professional present. E33
- Listen, try and understand what has caused the problem and then work out a solution for both parties to make it better. E25
- Establish a trusting relationship. Ascertain the families hopes and wishes. Establish what is achievable clinically. Support both clinicians and parents in understanding each other’s perspective to reach a shared understanding. K15
- Listening to parents. Validating their fears and feelings by reflecting these back to parents e.g. I'm sorry it has made you feel 'angry, annoyed, untrusting'. Giving them time to explain before suggesting why the information may be difficult to hear. Though if to do with how it was said rather than what was said, I would remind them I was not there but believe it was not intended to 'land so badly' or to upset or I would pull at any threads the family give e.g. ‘I've known Dr ? a long time and never had this’ or, ‘they seemed in a rush’ or …. K05
- Speaking to clinicians separately and addressing the areas of conflict to see how to resolve. Speaking to parents to find out their wishes and acting as an advocate for them. E19
- I try to approach it / de -escalate it by reframing from personal to using systems or evidence to give weight to the information that may be conflicting. My experience is

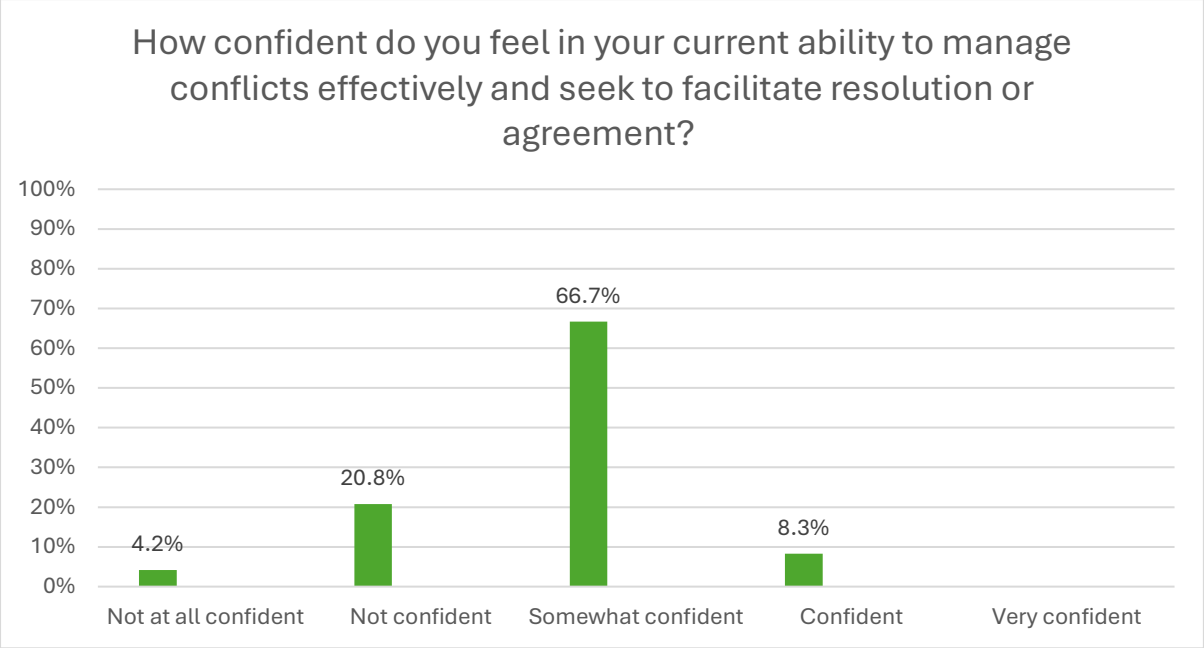
seeing others in conflict with parents. I also try and explore with my colleagues compassion and trauma informed language and practice as an approach. K08

- I do not directly encounter clinician / parent conflict. I have supported parents and clinicians to explore how the situation might have arisen and how they might constructively move forward. K01
- Try to listen and understand parent's point of view and see the parent in the context of the family and their wider world. Encourage professionals to be honest and transparent with families about their thoughts concerns and try to encourage respectful discussion. E05
- Listen to parents and try to understand their point of view, empathy, offering to speak with medics etc on their behalf. E12
- Talking it through, education, exploring alternatives. E26
- Listen, advise a break, regrouping, making formal complaints, seek support from higher management. K16
- Listening to the families to understand where the conflict lies - what can we do to work through the conflict in a calm manner. Good, open and honest communication is always the basis of resolving conflict. K18
- Discuss concerns with parents. Listen to them to try and understand what their concerns are. Try and reiterate the main aims of the clinician and reassure that the child's best interests are always central to care that is provided. Reassure parents that they know their child best, try to come to a solution that they are in agreement with. E04
- Taking the time to listen, most complaints are due to frustration and systems failures and families not feeling heard. Breakdown between clinician and parents can often be due to a perception / judgement and it is stepping back from those thoughts and approaching things from an appreciative inquiry mindset can allow the conversation to evolve and progress to be made in resolution. Also an understanding of what resolution feels like for the families and for the clinicians. K09
- Defusing a situation by listening to the family. E11
- Mediation, advocacy, informal resolution. If these measures are not successful, then follow the formal conflict resolution routes e.g. complaint processes. E37
- I always look at both points raised by each party involve and then come to a decision in the middle if its best appropriate. Everyone has the same aim and its [sic] what is best for the child. E29
- Try to meet with parents and listen to what they are saying but not offer an opinion, then discuss with professionals. Encourage parents [sic] attendance at MDT even if there needs to be a professionals meeting first. Advocate for parents during a meeting and check their understanding. Ask hospice medical teams to return to families and continue to explore understanding until a family are sure of what they are hearing. K10
- I explore the goal of care for the baby, child, young person and parents from a person-centred/family-centred approach trying to understand what is most important for all at that time. K13
- Listening to the concerns of both sides of the conflict. Being honest about the issues raised to both sides, or if I'm the one in conflict being honest about my concerns while trying to understand the opposing view. Trying hard not to blame or judge but be as objective as possible. Try to understand what is triggering the conflict. Don't appologise [sic] on other people's behalf until an understanding of the issues has been reached.

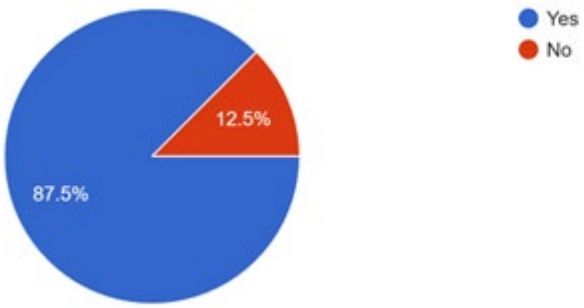
Appologise [sic], and be open to learning and reflection if this is required. Accept that perception is everything but might be altered with calm, mindful dialogue. K19

- Allow all parties space to discuss issues with an independent person. K11
- Listen, spend time with parents to explain and get there [sic] views. E27
- I would discuss the situation with the team lead/senior charge nurse. I would also seek advice from other colleagues where necessary. I would try to ensure the parents felt heard and supported and that I was deemed a mutual party in the situation to enable a trusting relationship. E18
- Listen to the family, give them time and space to express what they need to say, give them the option of having another family member with them-often a grandparent of the child. Try to understand what particular aspect of their child's care is causing the conflict. Try to explain the reasoning behind the decision. Offer the family to speak to someone else. E08
- Honest discussion, calm behaviour. E21
- Active listening, empathy, using teach back techniques- so I am able to understand the individual families [sic] feelings on the situation. Transparent and realistic conversations. Using skills learnt from EC4H [Effective Communication for Healthcare programme] or more experienced colleagues. K03
- Thorough conversation and explanation. Plan of action if need be. Seek advice from Senior colleague. E36
- Listening and empathy. E03

Q5 – How confident do you feel in your current ability to manage conflicts effectively and seek to facilitate resolution or agreement?
48 responses



Q6 – When faced with conflict in your day-to-day practice, do you know who to ask for advice and support?
48 responses



Q7 – If you answered 'yes' in Q6, please use the text box below to give more detail about who you approached. For example, this could be colleagues in particular types of positions, or committees or organisations, either internal or external to the NHS. Please **do not use any identifying language** in your descriptions (for example, use "nursing director" rather than "Nursing Director for NHS Lothian" and please **do not name any individuals**
40 responses (anonymous respondent code included)

- Line manager, peers, health colleagues. E34
- My line manager or a member of the family support team. E28
- In the first instance I would usually seek advice from the team around me, so senior nursing team- SCN's/ ANP's or duty doctor. If I felt the situation needed escalated quickly, I would make contact with the associate nurse director or medical director. K28
- Notify staff at senior level. E32
- Line manager and / or relevant family support team member. E02
- Line manager, colleagues who have positive relationships with the family or know them well, charge nurses. E14
- Line managers and colleagues within CHAS. K27
- I would discuss this with a senior staff nurse, then Senior Charge nurse. One of our medics or ANP's. E06
- My manager. K24
- Colleagues and line manager. K21
- Senior Charge Nurse, ANP, Doctor, Service Manager. E23
- Medical director, Palliative care consultant in NHS. Peers internally. Area social work team. Internal social work team. E33
- I would approach other staff members for advice/support. Senior managers/senior leaders within the team. E25

- Lead consultant, Clinical nurse manager, service director, medical director, Professional peers, MDT, ethics committees, legal team. K15
- I would ask those clinicians who are more senior or those with more information to support the conversation and follow up actions if any. K05
- Colleague, line manager, Senior Charge Nurse, service manager. E19
- I recently walked in to find a colleague and a consultant ridiculing me , I remained calm and advised them that I had heard every word they had said about me, I gave space and time however conflict management is only beneficial when both parties are receptive to hearing the other. my manager was extremely helpful and supportive during this time. K08
- External coach, line manager, trusted colleague. K01
- I would speak to my line manager in the first instance or charge nurses. E05
- Service manager, senior charge nurse colleagues, outside psychologist during clinical supervision. E12
- Associate nursing director or nursing director. E16
- I would speak to team lead in the first instance then escalate to my line manager or service manager if needed. E01
- Manager, Clinical Nurse Manager, Colleagues, Kindred, senior medical staff. K16
- My peer or service manager. K18
- Senior charge nurses. Nursing colleagues. Advanced nurse practitioners. E04
- Depends on the nature of the conflict and the context -line manager, more senior colleague (charge nurse/ ANP/ DR) nursing director, medical director. K09
- Senior charge nurses and social workers? E11
- Managers, HR. E37
- I would always speak with the line manager or charge nurse to raise any queries and then look to involve other health professionals when required. E29
- I would initially discuss with my PEERS then my line manager or a member of the team who I feel may be able to assist. I am not afraid to ask for help/support or to check what I am intending saying. K10
- I would discuss within my team between Nurses and Doctors. K13
- Medical Director, Nursing Director, direct medical and ANP colleagues. K19
- Clinical Director, Peer support. K11
- Depending on the circumstances, I would seek advice from a necessary colleague. For example the team lead/band 6/senior charge nurse or clinical nurse manager. In other circumstances it is appropriate to seek advice from the family support team, eg social worker, sibling support etc. Sometimes it is required to discuss with external parties such as community nurses or dietitians. It is important to gather as much information as possible to get a whole picture but also provide holistic care and support. E18
- Consultant on duty is normally the first person I contact. E08
- Charge Nurse, HR, Line Manager. E21
- Clinical Director, Medical Director, MNPI ([Maternity and Neonatal Psychological Inventions] services, Consultant in Charge, Clinical Nurse Manager. K03
- Senior colleague or Senior Charge Nurse. E36
- Team Lead. Senior Charge Nurse. E17
- Senior charge nurse, ANPs. E03

Appendix B – Google survey

Responses - Evaluation of the impact of conflict management training on paediatric practice – post-training evaluation survey

Q1 – participants entered their anonymous code, generated and given to them by CHAS in the participant information pack. Only CHAS know the personal identifiers for each participant. That code has since been replaced by the PI with a random generated code. This code can no longer be traced by to the individual.

Q2 – When you encounter conflict between clinicians and parents *in the future*, what approaches do you plan to use to seek to resolve or de-escalate that conflict? (Please describe in the box below in as much detail as possible)
13 responses (anonymous respondent code included)

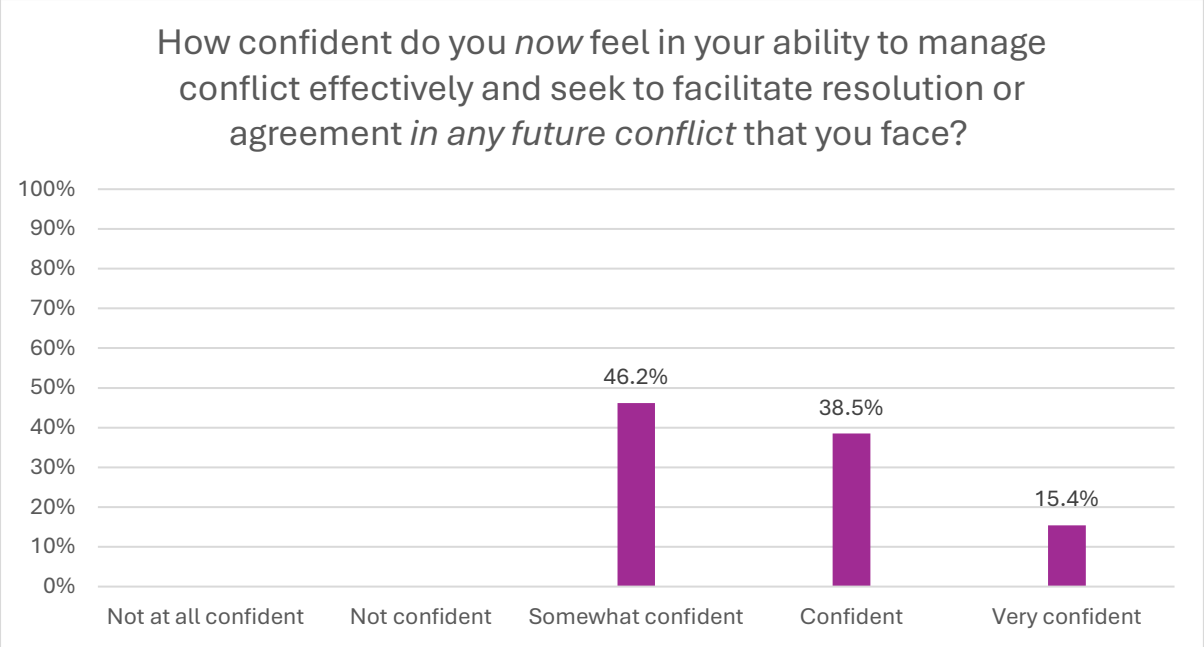
- Look for cues and triggers. K08
- Active listening, the models provided by MMF - stage 1 conversations, stage 2 conversations (responsibilities agreement). E34
- Active listening. E03
- Discuss use of mediation. K16
- Really listening to parents and demonstrating that I am doing so, encouraging others to do the same. Listening for cues. Try to establish common goal. Showing a genuineness in communication with the parent. E05
- Stopping, actively listening, holding silence, responding not reacting. Establishing a relational, collaborative relationship, trauma informed language and approach, kindness to self. K01
- Face head on, be less sensitive, take less personally, LISTEN. K23
- I would seek to have a conversation in a safe private space, where we were able to have a conversation without interruptions. Ensuring the [sic] both myself and the other party feel comfortable to begin the conversation. E32
- I would be more inclined to start de-escalation before the escalation when the initial indicators start to appear as opposed for waiting until the point that communication is beginning to break down fully. I would also be more inclined to listen to all the information before trying to reach solutions. I would not be as resistant to escalating to the next stages of conflict management if it was the appropriate thing to do. K09
- Address the conflict, listen, notice cues, paraphrase, pay attention to my language, don't get caught up in right and wrong and use a responsibilities agreement. 'Shut up, shut up, shut up!'. E37
- Preparing for the meeting i.e. getting into the right head space and having the relevant helpful information. Giving more time and availability to actively listen. Open questions to elicit more information on what is really going on for them. K05
- Use framework, open questions, actively listen. E27

- A listening approach without expectation to 'fix' the problem. Facilitate time for the parent and the clinician to hear each other and share information without being defensive. Take a break if tensions are high. Sitting with silence. K10

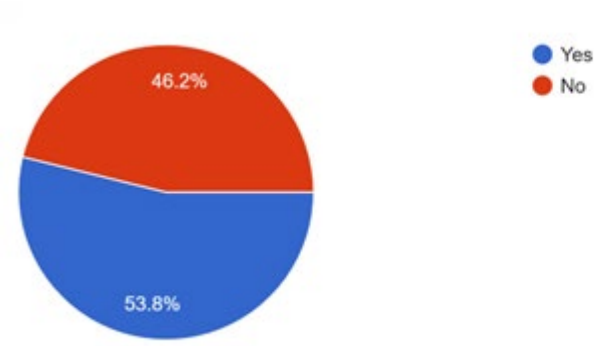
Q3 – How will the approaches you described in Q2 differ from your practice prior to attending the training?
13 responses (anonymous respondent code included)

- More mindful of own emotions and agenda. K08
- Previously I had no awareness of structures which could support conflict resolution E34
- Normally avoidance. E03
- Feel can explain the helpfulness of mediation and that it's not failure it's a way to try resolve situations. K16
- I don't think they will differ greatly it's just that I am going to be more conscious of it and I think makes me more confident in going into a conflict situation. E05
- These were all approaches I tried to use in the past and I will continue to try to do in the future. I need to be more conscious of kindness to self as I am highly critical of myself. K01
- More hesitant perhaps, take complaints personally. K23
- This doesn't change from how I would have approached the situation before the training. E32
- I would have been more inclined to try and find solutions before getting to the route [*sic*] cause of the issue. I also would have probably waited until the issue became a very apparent problem even though I was aware that there were going to be issues. K09
- Not greatly but I have got more ideas re noticing cue words, better wording to get people on board. The importance of making time, however short, is important. E37
- Often I don't prepare myself psychologically to enter into these conversations, which can have you on a back foot. You need the head space to listen, truly listen. Also giving appropriate time for the conversations, not rushing and taking time to get to the route of the problem. I felt the training session emphasised this well. K05
- Didn't know about framework before training, didn't use open questions much and I require to actively listen more. E27
- Trying to fix the problem, thinking of a solution whilst the parents is still talking, not allowing silence. K10

Q4 – How confident do you *now* feel in your ability to manage conflict effectively and seek to facilitate resolution or agreement *in any future conflict* that you face?
13 responses



Q5 – When faced with conflicts *in the future*, would you now seek advice and support from a different role-holder, committee or organisation than you would previously?
13 responses



Q6 – if you answered 'yes' in Q5, please use the text box below to give more details. For example, this could be colleagues in particular types of positions, or committees or organisations, either internal or external to the NHS. Please **do not use any identifying language** in your descriptions (for example, use "nursing director" rather than "Nursing Director for NHS Lothian", and please **do not name any individuals**)
7 responses (anonymous respondent code included)

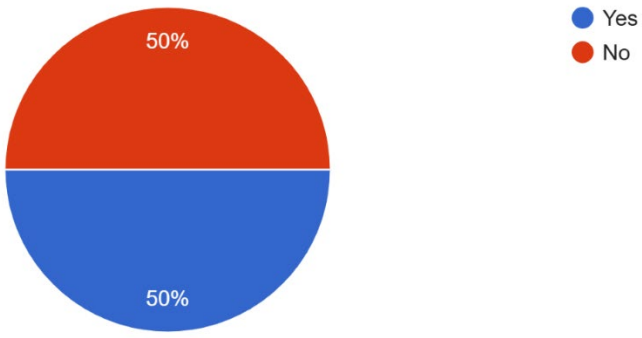
- Nurse director. K08
- Senior charge nurse. E03
- Senior management, discussion with third party to talk through situation. K16
- I would be more inclined to seek out a mediator earlier in conflict management someone who was not as close to the topic. I would also be more comfortable in that role of independent participant in conflict management. K09
- I would seek advice as i would have before from peers or those more senior but i would hope to engage other organisations to further support us when appropriate. K05
- Diana Nurse, Managers. E27
- Seek advice from QCAT [Quality and Care Assurance] team or line manager prior to the conversation. Potentially meet in advance to have better awareness. K10

Appendix C – Google survey

Responses - Evaluation of the impact of conflict management training on paediatric practice – 6 month follow-up evaluation survey

Q1 – participants entered their anonymous code, generated and given to them by CHAS in the participant information pack. Only CHAS know the personal identifiers for each participant. That code has since been replaced by the PI with a random generated code. This code can no longer be traced by to the individual.

Q2 – In the six months since you attended the Medical Mediation Foundation training, have you encountered conflict between clinicians and parents?
14 responses



Q3 – If you answered 'yes' to Q2, please use the text box below to describe how you approached these conflicts.
7 responses (anonymous respondent code included)

- Hopefully with compassion, patience, and curiosity. K19
- I believe I have mostly been using the skills/approaches that were taught on the course but this was through experience and skills from EC4H [Effective Communication for Healthcare programme]. However it did highlight the approach I was using and the rational for it. K03
- My approach hasn't changed drastically. I feel I will always listen to parents and try to create the safe environment to talk openly about their fears and hopes. In conflicts about treatment management at end of life, I will always approach this from a goals of care concept. What is most important to you right now as a family and how can we work together to achieve this. K13
- Took time to understand both points of view and to be as well prepared for meeting, found the best location to meet with the family allowing them to be comfortable,

Allowed time for the family to talk, didn't jump into silences but instead let the silence play out. Shared our points and when it was felt that this was not being heard, left the family with a written version of what needed to be shared and with contact information to respond to. Ensured follow up with the family and did not disregard their feelings. K07

- Alignment with parental expectations / fears . Establishment of trust with the family . Translation of family fears for health professionals and deliver assurances to alleviate fears. Develop an understanding of how the situation of admission was impacting on parental mental health/ health anxieties. K15
- After the conflict happened, I discussed with the parents after the incident in a timely manner that same day. We discussed the situation in detail. E11
- I advised parents that I was sorry to hear that they felt this way that I would remove myself from their care and offered for the family to speak to management re areas of concern, by the end of the day when I went in to the child's room the parent immediately apologised and explained that she had been overwhelmed and unfortunately I got the brunt of her feelings. K08

Q4 - If you answered 'yes' to Q2, how has your approach changed as a result of the training? Please **do not use any identifying language** in your descriptions (for example, use "nursing director" rather than "Nursing Director for NHS Lothian" and please **do not name any individuals**)
7 responses (anonymous respondent code included)

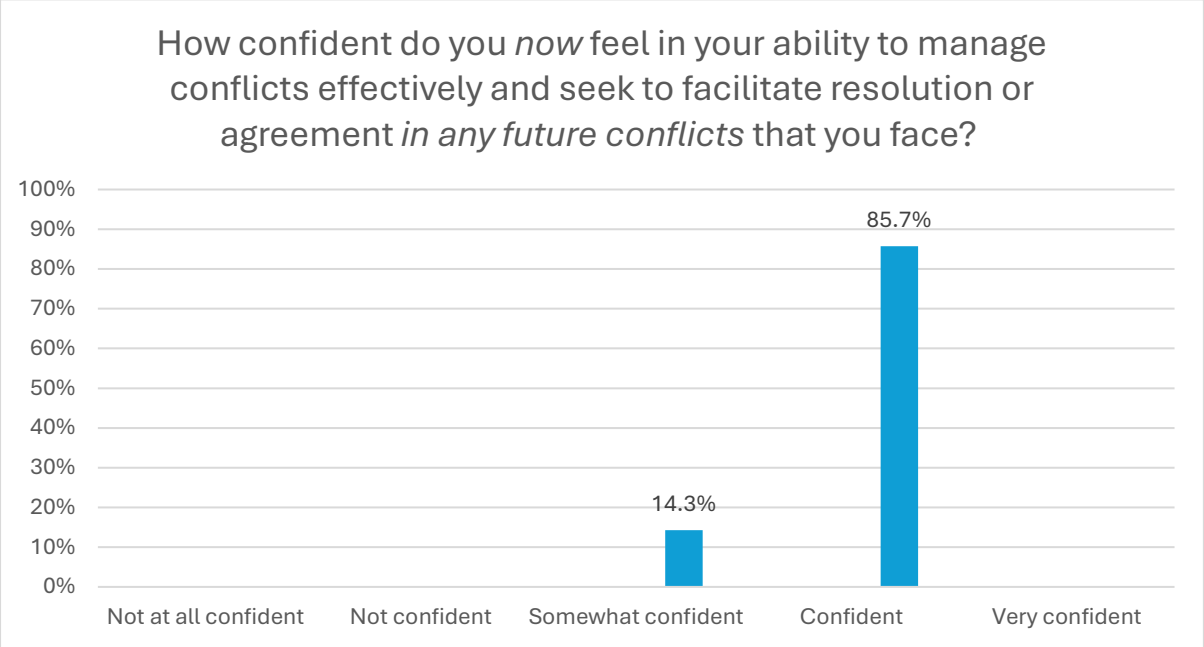
- it has made me more aware of the language I might choose to use and that listening carefully with curiosity and compassion to what is being complained about is crucial. K19
- I think the training emphasized the importance of active listening, reflecting/clarification and summarizing. K03
- The training gave me validation that the approach I adopt is sensitive yet honest and productive. The phrase 'tell me more about that' is always a helpful one to have in my back pocket. K13
- Not feeling uncomfortable in the silences and being more prepared ahead of such meetings. K07
- Early connection with hospital senior leadership team. Collaboration of communication needs for the family aided in parental engagement with services. Acceptance of change in pace of change / communication to allow family. K15
- From the training I took a lot from discussing it at the time instead of waiting. E11
- I feel better equipped to manage conflict and I don't feel as triggered as I used to, I know that in the moment there can be many reasons why a person responds but if you let them know you have heard them and what your intentions were and an alternative to help support them. K08

Q5 – If you answered 'no' to Q2, please use the text box below to describe how you now plan to approach *any future* conflicts, and whether your approach will be different as a result of the training? Please **do not use any identifying language** in your descriptions (for example, use

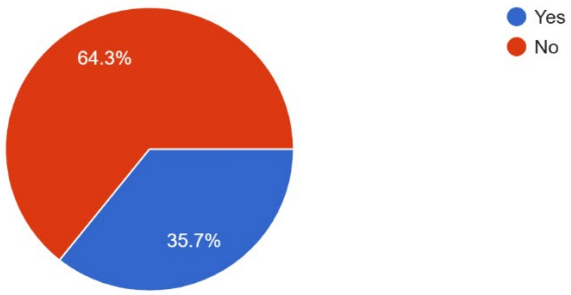
"nursing director" rather than "Nursing Director for NHS Lothian" and please **do not name any individuals**)
10 responses (anonymous respondent code included)

- Spending more time actively listening. Being more aware of the differences between health professionals agenda and the families. K03
- I would be more confident about saying less, listening more, acknowledging the other persons concerns and re-capping what I think they are saying and then attempt to find mutually acceptable way forward. E30
- I feel confident enough now to deal with conflict but feel I am better at dealing with problems before they reach the top of the iceberg. E29
- As above - Everyone has always something to learn and I learned a lot from the sessions but I feel my goals of care approach to communication is in close alignment to the principles taught in conflict management. K13
- My approach before the training was probably to plan and prep my answers before going into a meeting. I would now think about options however would not plan responses but try to really listen more and respond to what I'm hearing rather than what I think I know. K27
- The training has enhanced my understanding of driving factors influencing conflict. I gained confidence in not seeking to give a " defensive" to complaint but rather exploring the feelings behind the complaint. K15
- Prepare if possible prior to conversation. E03
- I think I would listen to what is being said and slowly pick apart bits and then give the person time to talk. I would let them know that I am listening and hearing everything they are saying. I think after the training it has highlighted that time is important and to give the person my full attention. E25
- I really appreciated the course reinforced with evidence that my preferred method of open and honesty and apologising for the system failures was the best way to manage conflict. The recognition and a trauma informed approach to establish the route cause. Acknowledging my own unconscious bias and naming those to allow for a more neutral conversation. the importance of silence and using it as a tool to really listen. K09
- What I believe is really important is giving families the opportunity to feel listened to, to discuss and describe anything they need to and not to seek solutions. K10

Q6 – How confident do you *now* feel in your ability to manage conflicts effectively and seek to facilitate resolution or agreement *in any future conflicts* that you face?
14 responses



Q7 – In the six months since you attended the training, have you needed to access advice and support in dealing with a conflict?
14 responses



Q8 – If you answered 'yes' in Q6, please use the text box below to give more detail about who you approached. For example, this could be colleagues in particular types of positions, or committees or organisations, either internal or external to the NHS. Please **do not use any identifying language** in your descriptions (for example, use "nursing director" rather than "Nursing Director for NHS Lothian" and please **do not name any individuals**)
6 responses (anonymous respondent code included)

- Risk Team re SAER. Clinical Director. K03
- I access peer support through my local team regarding how best to progress a situation. As a team we would often approach a situation as a pair so we can help support each other throughout the conversation. Parents are often in conflict with disease specific teams and our team in the hospital is seen as a neutral space where parents will often explore complex decision making in the safe space we create for them. K13
- I have utilised my peers and leadership group more to share and discuss ways to approach situations as they have all attended the training also. This has aligned with personal and professional learning around Trauma Informed Approaches and made me much more mindful of language. K27
- Spoke to my senior charge nurse about the situation. E11
- Staff conflict and approached my immediate line manager for support and discussion in managing the situation before meeting with the staff members. K10
- Service manager about a SN approach that I felt I was having difficulty understanding, since then I have been able to understand how she learns and comprehends. K08

Q9 – Reflecting on your experience in your day-to-day practice since attending the training, can you describe any situations where the training you attended has caused a change in your practice? Please **do not use any identifying language** in your descriptions (for example, use "nursing director" rather than "Nursing Director for NHS Lothian" and please **do not name any individuals**)
13 responses (anonymous respondent code included)

- I'm more aware of the language I use in general but can't bring to mind any specific situation [sic]. K19
- Difficult to give direct example. I feel that by spending more time listening and clarifying gives a deeper understanding of the situation. The families value this. More awareness of non verbal behavior's [sic]. K03
- More confident. E30
- I feel more confident in talking things through with staff and identifying any problems before the reach conflict stage. E29
- As above, this training aligns with other work and my personal growth around listening and providing clear and concise context/ boundaries. K27
- Yes, I try to ensure I have all the information before heading into a situation, I will write down a summary of our discussion as soon as possible so that the other person has a written account to reflect on too. I am happy to sit in silence if that is needed too. K07
- In the general context of practice I am mindful of being more curious to families [sic] potential grievances and the root for those misgivings. In exploring this with families it can help them recognise that this at times is situational rather than a neglect of their care thus limiting the escalation to conflict. I have definitely developed my active listening skills. K15
- More likely to have difficult conversations. E03

- If there is any conflict with staff, I have been trying to do this in a timely manner but also encouring [sic] staff to do it more timely instead of passing it onto someone else to do. E11
- I have been in a situation during a difficult conversation that I made sure we moved from a busy room to find a quiet area. I made sure I didn't have an agenda of questions I thought I needed to ask. Instead I listened and then prompted questions from what was being said. I think time and listening is something I am much more aware of. E25
- I appreciate how important silence is as a tool and I have been working on my own discomfort with this. Also trying to encourage to holistically at any issues that occur remembering that what may have caused a reaction is most likely not the route cause but an accumulation of factors. As with everything behaviour is communication and if we remove our own emotions and biases from a situation we are better placed to have effective conversation. It is also vital to have an awareness of how you are coming across to others. K09
- In every conversations [sic] to be honest. I definitely remind myself that it is not my responsibility to fill a silence and often leaving the silence allows either the staff member or the family member to further elaborate on their experience. K10
- Yes I feel better able to express how a situation makes me feel and draw it to a respectful close with a view to reapproaching the issue at a later time. K08

Q10 – If you have identified changes in your practice, can you describe how, in your view, that change has impacted or benefited parents or other clinicians? Please describe these situations in the text box below. Please **do not use any identifying language** in your descriptions (for example, use “nursing director” rather than “Nursing Director for NHS Lothian” and please **do not name any individuals**)
10 responses (anonymous respondent code included)

- I have been asked to directly support in situations where conflict has become apparent. K03
- More willing to mediate between staff when required. E30
- I have always thought of myself as very approachable however had been finding it more challenging within my leadership role to remain open and approachable but also to provide safe and effective guidance and boundaries. This training helped me to see the importance of honesty and consistency in approach and language rather than just a focus on 'being nice.' K27
- I hopefully have a more consistent and considered approach to these situations which supports myself and supports those I am working with and for. K07
- I have been able to model a listening approach to families whilst exploring their feelings whilst resisting the temptation to defend service or oppose their views. This has allowed clinicians to recognise the families [sic] needs to be heard as a priority for developing trust and reduce the progression to conflict. K15
- Increased confidence. E03
- I think it has benefitted me in my role as support worker but also it is of benefit to my colleagues and the families I am working with everyday. The training has given me more

confidence in these moments. It is something I will continue to build on and take a little bit away both good and bad when in situations with conflict. E25

- I have continued to work on my understanding checking with those that I have been involved in conflict with. I am trying to follow a more of a coaching methodology when working with others and ensure awareness of my own behaviour and unconscious bias. K09
- I believe I get a deeper understanding of the staff member or family members thoughts and wishes or challenges. I can then better plan what support can be given and also negotiate how this is given and by whom. K10
- I personally feel more confident, I feel that it has given me the confidence to approach difficult situations and express how I feel and what my intentions were. K08