Thinking differently about complaints in the NHS

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ABSTRACT

NHS complaints have been both the precipitant and subject of numerous recent reports, inquiries and investigations. They are viewed and treated as a wholly negative aspect of NHS activity and consume significant resource and time in addition to the emotional impact on both patients and staff. Currently the stance taken by NHS providers is defensive and process-driven with little attention to the subject of the complaint and how this might provide useful and constructive information (delivery model). With much focus on patient experience and how this can be improved, complaints, if incorporated into a much bigger framework encompassing patient feedback, satisfaction and experience, could be used to constructively develop and shape healthcare delivery. Use of complaints to inform experience based co-design and collaboration could transform some healthcare services for the benefit of patients and healthcare professionals (relational model). The NHS must learn how to effectively harness patient feedback, including complaints through all available channels: written, verbal and via electronic media. Limited resources mean not everyone can have the treatment they want or need when and where they want or need it and in building an anticipatory approach to complaints by making it easy for patients by inviting feedback, good and bad, training staff to act appropriately and thinking differently by seeing complaints as an opportunity rather than a threat, could contribute to driving improvement across healthcare and making the NHS the high performing organisation it aspires to be.

KEYWORDS: Complaints, patient experience, quality improvement, relational, responsive

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Relentless media focus on the negative aspects of the NHS, whether these are failings in basic care or poor outcomes from specialised clinical services, presents a depressing and demoralising picture for patients, the public and healthcare professionals. The recent plethora of investigations and reports into and about NHS services make chilling reading, especially because many have been prompted and informed by patient complaints.[1,2] These accounts indicate that the response to complaints is often characterised by indifference, lack of compassion and even resentment. In addition, a recent Healthwatch report indicated that more than 70 organisations are currently involved in NHS complaints management in one way or another, confirming the impression that the process is unnecessarily complicated and inefficient for both patients and healthcare providers. Less well emphasised is the fact that many staff also complain and highlight concerns about poor care partly, it would seem, because this is seen as disloyal or unprofessional, rather than a mechanism to support change and improvement.

To change the generally negative interpretation of complaints, we need to think differently about how they are elicited, responded to and used to influence service provision. This will require a paradigm shift in our philosophy, such that we consider all facets of patient feedback collectively to create a positive opportunity to do things better.

Facts and figures

Many data are collected concerning complaints about the NHS: annual figures from the Health and Social Care Information Centre (HSCIC) show that, in 2012–2013,[3] there were 162,000 complaints about NHS care, equivalent to approximately 3,000 per week. In 2008, a National Audit Office Report on feedback and learning from complaints indicated that two-thirds related to experiences in secondary care, and that the estimated cost of handling and reviewing them was £89 million, requiring 880 whole-time equivalent staff.[4] This is in the context of the NHS in England providing care free at the point of delivery for more than 50.7 million people with over 1.5 million contacts with patients and their families every day, suggesting that there is approximately one complaint for every 3,380 contacts. Numbers of complaints against the NHS and other public services are increasing; General Medical Council (GMC) complaints about doctors increased by 23% in 2012, all complaints about communication increased by 69% and those about lack of respect by 45%.[5] In addition, there is evidence to suggest that more people would complain if: they knew how to; felt that it would not impact on the way in which they were treated or attitudes towards them; that they were supported in doing so; and/or knew that something positive would result. This is despite the fact that users generally tend to be more satisfied than dissatisfied with public services[6] and appears to demonstrate, first, that patients expect to receive high-quality, safe healthcare and second, that they do complain if it does not meet their expectations and would complain more if they

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could. Finally, those complained to or about deploy significant resources to deal with complaints, many of which are linked to the process of management rather than to the effective use of the information to change and improve services and care.

Complaint reviews

Complaints about NHS care have been the subject of numerous formal Government-sponsored reports, most recently in the form of a *Review of the NHS hospitals complaints system; putting patients back in the picture*, co-authored by the Right Honourable Ann Clwyd MP and Professor Tricia Hart.[7] This review was instigated by the prime minister to investigate the handling of complaints and concerns in NHS Hospital Care in England and, in doing so, to make recommendations both to publicise the systems for making complaints and concerns known, and to highlight the way in which organisations receive and act on such complaints and concerns from board to ward, and how they are (or are not) held to account for the manner in which these matters are dealt with. This detailed, wide-reaching and emotive report was informed by patient and carer stories and experiences, but is focussed on the process of complaint prevention and management. Thus, improving the quality of care, the way in which complaints are handled, increasing perceived and actual independence in the complaints process and whistle blowing are all covered, although examples of good practice are cited in the final chapter. It is impossible to find fault with this report, but in many ways its findings mirror those of others published by the Parliamentary and Health Service Ombudsman,[8] the National Audit Office,[4] the Francis Inquiry, the Health Select Committee,[9] NHS Complaints Reform 'Making things right'[10] and others that have emerged over the past decade. All focus on the process; how to complain, how to handle complaints, timescales, independent review, training staff and regulation, rather than on improving the systems of care so that complaints are not required. The collective view appears to be that the current complaints system must be made to work.

Why do people complain?

The NHS Constitution states that patients have a right to receive a professional standard of care, delivered by appropriately qualified and experienced staff, in a properly approved or registered organisation that meets the required levels of safety and quality and that will continuously monitor and improve its performance.[11] In addition, patients have the right to complain, and to have their complaint acknowledged and investigated. NHS organisations have statutory obligations in relation to complaints management and, from April 2011, have been required to collect and submit data on the number of complaints received and the number upheld to the HSCIC. In the Oxford English dictionary 'to complain' is defined as to 'express dissatisfaction with, announce that one is suffering from, state a grievance to authority, emit mournful sound'. There is little that is positive to associate with this definition; the Francis Report in particular includes many mournful accounts of suffering by patients, their families and friends.

During their review, Clwyd and Hart received testimonials from over 2,500 patients, relatives and carers, mostly recounting their experience of poor-quality treatment and care in NHS hospitals. The key areas highlighted were; lack of information, lack of compassion, loss of dignity, poor staff attitudes and lack of resources. In addition to these, Simmons and Brennan, in a review of complaints about public services in general, cited failure to do something when promised, inefficiency, unfair discrimination, inconsistency and inept and incompetent service as a result of apathy or inattention as forming the substance of many complaints.[12] Data from national public services show that the three most common causes for complaint are late or slow service, and staff attitudes and competence. Conversely, delivering what users need appears to be the strongest driver of satisfaction with public services.[6] Healthcare has to date been delivered in a way that organisations and professionals consider to be appropriate to meet those needs, but it is apparent that what patients need and want is often at odds with what the NHS is prepared to provide, and this is a root cause of many complaints.

The NHS was founded in 1948 on utilitarian principles; the greatest good for the greatest number. In other words, it was designed to deliver healthcare free at the point of delivery to those who needed it in a cost-effective and efficient way funded by the taxpayer. Currently, there are 300 million general practitioner consultations per year and 21 million visits to emergency departments. The scale of this organisation, the third biggest employer in the world, cannot have been imagined or envisaged at its inception. Increasing demand, spiralling costs and patient expectation of access to any and every innovative treatment as and when required have pushed the NHS beyond its limits; current efforts to make £20 billion in productivity savings from the NHS budget mean that there are and will continue to be limitations on what can be provided, such that not everyone can receive the care they need or want immediately. This will, and does, cause consternation for users despite the fact that it is not remotely surprising for those providing healthcare or in Government. People complain because their expectations are not met and some have higher expectations than others. Managing expectations is important if the needs of one vociferous element of society are not to eclipse those of the less forceful but potentially more needy. There is no justification for poor service, all care should be delivered with kindness and compassion but society needs a more realistic approach to, and understanding of, what the NHS can deliver.

Being complained about

In relation to healthcare, two main groups of complaint can be identified; those against organisations: waiting times, parking, cancellations and the like; and those relating to individuals, including their attitudes and communication skills and the clinical care that they provide. Although both categories should be embraced, explored, managed and responded to systematically, as set out in The Patients Association's *Speaking up complaints project report*, the impact on healthcare staff complained about can be significant and have a direct affect on their ability to respond appropriately.[13] Among previously published reports, the need for better education and training of healthcare professionals in handling complaints is universally included as a recommendation. However, there has been little attempt to explore the wider implications, both emotional and professional, for those complained about. In

the Parliamentary and Health Service Ombudsman report *The NHS hospital complaints system; a case for urgent treatment*, the two most frequent reasons for complaints about the handling of complaints were the lack of acknowledgment of mistakes and poor explanation. Specifically, failures to listen, to share information openly and to apologise with sincerity and tact are cited. In the HSCIC data for 2012–2013, the largest proportion of written complaints was attributable to doctors (47.1%), with nurses, midwives and health visitors responsible for 22.1%. The main subject areas for complaints were all aspects of clinical treatment, poor attitudes and failures in written and oral communication. Information from the GMC, the UK professional regulator for doctors, shows that approximately 1 in 64 doctors are the subject of a complaint each year, most commonly related to communication and openness. Although it seems appropriate to develop education and training programmes directed both generally at enhancing communication skills and, more specifically, at responding to and dealing with complaints, such an approach is based on the premise that complaints and claims are *ad hoc* or random events linked to patient attitudes and behaviour rather than the attributes of healthcare professionals.

A study to determine the distribution of formal patient complaints across the medical workforce of Australia attempted to identify the characteristics of doctors at risk of incurring recurrent complaints.[14] Some 3% of the workforce accounted for 49% of complaints, and 1% accounted for a quarter. The authors concluded that a small group of doctors account for more than half of all complaints lodged with the relevant Australian body and suggested that predicting which doctors are at high risk [male, older age, specialty (plastic surgery, dermatology, obstetrics and gynaecology, for example) and a history of previous complaints] is feasible; in this way, interventions could and should be targeted towards these individuals, particularly because those who have recently been the subject of a complaint are at risk of a further episode in the following 6 months before this then declines. An alternative explanation for these findings is that certain specialties, rather than individuals, are more likely to attract complaints. It is notable that those practicing plastic surgery and dermatology are high risk for complaints and this might reflect the patient population (appearance being a particularly emotive subject); it might be that failure to achieve satisfactory results from treatment or intervention results in complaints regardless of how professionally and compassionately care was provided. Targeted training in communication, managing expectations and complaints for practitioners in certain high-risk specialties would seem sensible.

Consequences of complaints

There is evidence to support the notion of a 'malpractice stress syndrome'[15] in relation to clinical negligence litigation against medical staff. This is characterised by avoidance of certain patients, taking early retirement and discouraging others from entering the medical profession. The impact of litigation is often insidious and might be regarded as a major life trauma that requires positive coping strategies, cognitive reframing and personal support systems to manage it effectively.[16] Complaints can be as stressful to handle as litigation. The book *Intelligent kindness* describes how healthcare professionals frequently evoke defence mechanisms to protect themselves from what is an emotionally traumatic environment.[17] Defensive styles of coping can become entrenched and the ability to feel kindness and compassion recedes. The result might be what patients see and hear when they make a complaint: someone who has lost the ability to understand their perspective, respect their view and do something about it. The authors go on to suggest that clinicians need assistance and support in managing feelings of guilt, failure, anger, hatred and dependency, and to accept that they are not perfect. Techniques such as compassionate mind training[18] that teach the practitioner to accommodate the feelings and emotions provoked by distressing situations more effectively have been successfully used in the field of mental health and could be readily translated for use in undergraduate and postgraduate medical training. Kindness and compassion are directly linked to the duty of care and the ability to pay attention, empathise with and make sense of what patients need and experience, but do require effective self management, awareness and practice.

Similarly, the move towards a statutory 'duty of candour' through which clinicians are required to inform patients and carers when things have gone wrong is another approach in which clinicians, rather than having the anxiety and uncertainty about what should and should not be disclosed, have permission or indeed a mandate to disclose. This might paradoxically make it easier to be open and honest, which is a key demand of complainants.

Thinking differently

A more refreshing, thoughtful and positive approach to complaints is described in *Grumbles, Gripes and Grievances; the role of complaints in transforming public services*.[12] Although using much of the same background material, this piece eloquently sets out a whole new way of thinking about complaints as a stimulus for innovation. The authors describe how currently the NHS is based upon a 'delivery' model with patients as passive recipients of a service-focussed, one-size-fits all, centralised but disjointed system using top-down decision making that defines people by problems and needs, with little use of information and communication technology. They propose a 'relational' approach that is outcome-focussed, flexible, joined-up, integrated and facilitative; and that acknowledges citizens as collaborative partners and active co-producers, in an open and transparent, listening and responsive system. Within this relational model, complaints can be used to identify and prioritise need, highlight opportunities for change, challenge established wisdom, co-create and co-produce solutions, as well as uncover system failures. Within a 'delivery' model, complaints result in fear, are challenging and unsettling, and failure is leapt upon by media and the public. By contrast, in a 'relational' model, complaints are regarded as a powerful form of knowledge and can be used to stimulate innovation if collected, analysed and acted on effectively, allowing organisations to build competence in consumer knowledge management, innovation and delivery.

The NHS is awash with data but spends insufficient time transforming that data into useful information or organisational knowledge. Instead of embracing patient

feedback, of which complaints are one element, and integrating it effectively into strategies for changing care models and systems designed around patients, it is regarded as something to be resisted or fought against, and which gets in the way of delivering care in a way that suits the organisation. Attributes that would demonstrate that the NHS is ready for effective consumer knowledge-enabled innovation include open communication, identification and prioritisation of consumer needs, exploring new territory, including opportunities for co-creation and co-production, creativity, ongoing evaluation and strong implementation skills. Complaints would inform these elements by providing intelligence, new insight and perspectives, and expanding the knowledge base and highlighting risks or failures. Seen in this context, complaints should be viewed as a wholly positive contribution to the future design and shape of healthcare. To meet this challenge requires a paradigm shift in attitudes, enhanced communication skills and the determination to commit time, effort and resources to work in partnership with patients and communities. Evidence of the success of this approach in healthcare is emerging (Box 1).

The Future Hospital Commission

The future hospital: caring for medical patients report was published by the Royal College of Physicians in September 2013 in response to several investigations and reports highlighting a healthcare system that is ill-equipped and, importantly, often unwilling to respond to and meet the needs of patients. It describes hospitals struggling to meet the demands of an ageing population with complex clinical needs, systematic failures in delivery of coordinated care, a looming crisis in medical workforce provision, and poor communication and information sharing; a classic example of a 'delivery' model that is found wanting in many aspects despite the best efforts of those who work within it. The approach described is founded on a new set of principles focussed on effective and timely access 24 h a day, good communication, seamless transfers and staff supported to deliver safe, compassionate, high-quality care. The new model shows a coordinated system with stronger integrated links between hospital, community and social care aimed at providing care how and where the patient needs it. This is a significant step towards the 'relational' model, with services integrated with peoples' lives, joined up, networked and outcome focussed, informed by patient experience at every stage. The Patients and Compassion work stream of the Future Hospital Commission (FHC) highlighted the fundamental importance of enhancing the overall patient experience of care[19] and making a cultural shift in the way in which the NHS engages and works with patients, not only through shared decision making and experienced-based design, but also by ensuring that the future healthcare system is built on an engaged, healthy and productive work force that is well led, supported, satisfied and appropriately resourced with a resultant innovative plan for medical care organisation and delivery.

Within this new model, and fundamental to how it evolves and develops, must be a system for consumer knowledge management. To provide this, we need to open as many channels as possible to receive feedback from patients, both positive and negative. Complaints can be formal or informal, verbal or written, and directly or indirectly supplied via social media, individual, collective or third-party advocacy services. Whereas previously patients would look for formal routes to communicate, they now tweet, blog, email and interact with a global community, thereby rapidly generating a groundswell of views and opinions. NHS organisations must actively embrace this by using such information as an opportunity to move forward, engage and interact with patients in the ways in which they wish to be interacted with, so they feel part of their own care management, trust those working with them to deliver it and feel able to highlight deficiencies and problems as easily as they are able to say thank you for good care, which they often do.

Box 1. Prioritising patient experience

The Northumbria Healthcare NHS Foundation Trust is an award-winning organisation when it comes to quality of care, service redesign and patient experience. The Trust provides acute and community health services and adult social care to more than 500,000 people in the North East, running nine hospitals and employing 9,000 staff. The Trust vision is that the patient is at the centre of all activity and it has committed significant resources and time to collecting and using patient experience data in a way that informs service and quality improvement. The Trust has a quality council and a director of patient experience (one of only three in the UK). The Trust approach demonstrates clear evidence of 'consumer knowledge management' using multimodal feedback, including exit and postdischarge surveys, patient advocates for those with dementia, face-to-face interviews with inpatients alongside complaints, incidents and claims information. Data are analysed and fed back to wards and individual consultant staff within 24 hours and are shared with patients, families and the public. Patient experience data have been used to monitor service redesign for the Trust hip fracture pathway; mortality has been halved and Northumbria provides leading NHS care for the best-practice tariff and time to surgery. The Trust has recently been named as a site of best practice in the response of the Department of Health to the Francis inquiry.

Conclusion

People, and patients in particular, make complaints when their experience does not match their expectation and because they think healthcare staff and organisations will care enough to acknowledge and respond to their complaints in a respectful and constructive way. Robert Francis stated in his report on the events at Mid-Staffordshire NHS Foundation Trust that 'it is far more effective to learn than to punish' and that 'within available resources … patients must receive effective services from caring, compassionate and committed staff'. He also laid significant emphasis on the 'duty of candour'. In the author's view herein lie three important principles relevant to complaints. First, they should be viewed as an opportunity to learn, improve and innovate, bringing patients and healthcare providers closer together to work within a relational model in pursuit of high-quality, safe and effective care. Second, in light of the fact that resources are limited, the NHS should expect,

anticipate and embrace complaints because resource cannot match demand without significant increase in investment. Third, in line with the duty of candour, openness and honesty about the limitations of the NHS should inform public expectation. Staff in all professions, including management, and at all levels, should receive generic training in managing and responding to patient experience feedback, including complaints; whereas those working in high-risk specialties should undergo targeted and specific coaching. Complaints are a rich source of information when considered alongside other forms of patient feedback and some trusts are already harnessing this information with demonstrable benefit. By thinking differently, the NHS could utilise complaints to positively inform healthcare design and delivery and drive it closer towards what those working within it would like to deliver and those whom it serves expect to receive. ■

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