"My Own Anger Propelled Me" - Observations driven by a study of patients' complaints to a NHS hospital in London

"Anger propelled me" - these are the words of a complainant about a healthcare experience - her anger and emotion was shared by many who participated in a recent study of complainants at a London hospital. Bad experiences with the health service can create deep and lasting feelings and emotions which complainants then bring to a complaint handling system that does little or nothing to calm and address those feelings - just the opposite.

The Roots of Obsession

I have done lots of complaint handling surveys and have got used to reading and recording the views of angry and upset users. But what I read in the returned questionnaires moved and saddened me in a way that I had not expected - recollections of events that had happened in some cases over a year ago were still so sharp and painful in complainants' minds. Emotion drives persistence and determination - which in a minority shades into obsession - creating expense and disruption for NHS people whose energies and time could better be directed at their primary duty of care. Of course, they too have emotions and feelings. We must avoid complaints creating a toxic cocktail of disappointment and despair gulped down by complainant and health worker alike. The hangover is crippling and made worse by the gloomy prospect of a stern telling-off from teacher - the Ombudsman. Or even worse perhaps - having to do it all over again because the Healthcare Commission says so and it still goes to the Ombudsman.

Lots of Advice - Not Many Facts

A lot is written about NHS complaint handling. Much advice is given and guidance written. We plead guilty to having contributed to this process ourselves writing guidelines for the NHS in Wales and for the Healthcare Commission.

This abundance of advice is not matched by data on what actually happens at the front line. What emerges eventually into the public view comes from fully 'super-escalated' complaints that an Ombudsman has considered and decided.

The Ombudsman then adds to the volume of suggestion and recommendation. Ann Abraham has written about what she would want to see in her report 'Making Things Better?' (love the question mark) . Again here, the suggestions were visionary and broad identifying elements such as 'leadership, culture and governance' and 'customer focus, accessibility, flexibility and transparency'. The Ombudsman to be fair does go on to offer descriptions of what she means. For example:

Leadership, culture and governance 102.

This will involve the Boards and Chief Executives of NHS bodies creating a ***culture of openness and learning****. There should be clear standards of behaviour set and followed by the leadership of each local organisation, and the* ***monitoring of performance*** *on complaints by managers and by the Board. Managers need to ensure that arrangements for complaint handling are* ***well connected with clinical governance and quality improvement activity****.*

How can we begin to translate these exhortatory generalisations into action on the ground without some closer understanding of what has to change to achieve these goals? Are there measures that will help to demonstrate that the goals have in fact been achieved? The survey we did demonstrates that such measures do exist and that they provide actionable data (going well beyond the simple and rather uninformative 'satisfaction' measure) that can form the basis for improved quality and satisfaction.

We have never seen or heard of what we would consider comparable studies about complaint handling at local hospital level. By 'good', we mean rather a piece of research that takes complainants back through the experience of having had a complaint and what it was that happened to them. How did they feel about that? How satisfied were they and would they say to their friends that it was worth complaining? Complainants have a very important role to play in improving the way problems are identified and sorted out.

Small Sample, Big Conclusions

One research study conducted by us for a Foundation Hospital Trust in London cannot answer all the questions. The data are based on a small sample of cases that had been managed by the complaints office in the previous 17 months. We make no claims that it is representative of all complainants who escalated their complaints in all hospitals and the small numbers means we must treat the data with caution. However we have been in the complaints business for a while and can with confidence draw some general conclusions that should help others even when those conclusions are based on only a few responses.

Our first conclusion is that the findings do help managers look beyond satisfaction and understand better the complainants' perception of other parts of the process. A low satisfaction rating is always depressing but if you can understand what parts of a process affect it and if changed, can push it up, there is a basis for action.

We need to know more about the origins of dissatisfaction and help avoid that expensive and prolonged process of the escalated and super-escalated complaint. If more problems were dealt with earlier and fewer escalated complaints generated, the money saved would be enormous and the satisfaction of users greatly increased. In our survey, 1 in 4 of the complainants said they were contemplating or actually had taken their case on.

II. How Much Money Would be Saved?

We were only asked by our client to gather complainant data so there was nothing on this in our survey. So we will construct an estimate.

The Health Services Ombudsman had in 2004/5 a case load of 2478 health service-related cases which cost £11,229,000 to handle - we will call this a cost per case of £4500.

That is of course just for starters. We do not know what Trusts spend (the Trust we worked with has no figures) for handling the case up to three times - once at the front line when the problem was first mentioned, the escalated complaints unit in the Trust, then again in that same unit when questions arrive from the Ombudsman. Actually make that up to 4 times because the Healthcare Commission is currently sending back 27% of cases because they feel more could be done at local level.

If we say charitably enough the Trusts' costs per case are half those of the Ombudsman and that the first opportunity to handle is costed as zero being part of the general costs of care, then the Trust may spend up to almost £7000. This is a low end costing.

How does £20,000+ per case grab you?

If the Trusts' costs are actually the same as the Ombudsman's (they could easily be higher in a fully escalated and investigated case involving the time of many senior clinicians and managers including the Chief Executive as opposed to the managed costs of an Ombudsman case team), then their cost to handle might be £13500 for a three time go around. Add back the Ombudsman cost and we are getting a cost per case of £18,000. Would you like to make that more? Easy - add in the costs of the Healthcare Commission and we are over £20,000 per case.

£1,000,000 Saved

Stop 50 cases @£20K going to the full process all the way to the Ombudsman and on this estimate, we have saved £1 million pounds of public money.

Any advance on that? Let us get back to the actual research.

Angry and Sad

Our second conclusion echoes the quote that forms the title of this piece. The health service does not recognise that complainants are driven by emotion. Another quote will give the flavour

"*I sincerely hope that no member of my family or friends is ever admitted to this hospital). Your negligence killed my mother- and to have to watch for 3 months just how shoddy your hospital is run has opened my eyes to a world that I never thought existed. Disgraceful- is what I think ...*"

The NHS complaint process is an adversarial, investigation-based, inquisitorial process that seeks to establish 'facts'. In doing so, it disguises and hides the emotional aspects by throwing the fire blanket of process over the blaze of feeling. This may dampen feelings down - it rarely extinguishes them; rather banks them up - so making things more comfortable for the managers and clinicians involved - the dispassionate path of process can reassure those whose conduct and judgements are being challenged. They feel safer if the process looks even-handed and 'fair'.

Excluded and Invisible

To the complainant of course, whose feelings are being ignored and tidied away in the interests of process, this looks like indifference, condescension or at worst total exclusion from an approach which is then seen as favouring the insiders. The dispassionate process disarms the consumer whose major weapon is emotion. The NHS is not of course alone in creating a process like this - organisations everywhere manage the emotions and feelings of their customers. The worst do this by ignoring them. More enlightened ones at least recognise and respond to the feelings.

Burnout?

Unrecognised emotional conflict burns out customer complaint managers - being the fire blanket involves stifling not just their customers' emotions but their own as well. If they get as worked up about service failure and poor quality as their customers, lips are pursed and careers ended - 'going native' in the customer cause is the ultimate sin - not very 'professional'. So much for all those management tomes and CEO pronouncements about passion for the customer - demonstrate it and you are seen as demented.

But things do change and improve as a result of complaints. The shame is that the complainant never gets to hear about this. Achievements are buried away in the hospital's monthly quality report. One example of an actual internal report will suffice to make this point.

"*All A&E doctors are to receive training in response to new guidelines for patients presenting with back pain. Physiotherapists will also work alongside doctors in A&E. As a result of a complaint received in Urology, there is more flexibility in allowing relatives to interpret and translate for patients. One investigation in maternity highlighted a need to review the way care is provided to women who are admitted with intrauterine death and particularly, a designated area for women who are having a stillbirth*"

III. Complainant Expectations and Avoiding Escalation

Complainant Expectations

We recommended that complainants be told. Involve them in the solution - do not just characterise them as being part of the problem. When things improve, dish out the praise to all involved including the users, patients and carers. 45% of the complainants surveyed recorded themselves as being 'very dissatisfied' with the aspect of the final letter that 'described how things would be improved'. Yet all the guidelines about complaint handling acknowledge as a complainant motivation, the wish to avoid others having to go through the poor experience. Complainants who have seen a leaflet or listened to the news have been 'trained' to expect this as an output and they do not see it.

The users' eye view

Their observations and inputs can be acute and detailed

"*in this year (2005) you have had the following continuing problems. your disabled toilet facilities for outpatient are excellent but those for inpatients are largely of an unacceptable standard. There are still not bath (bathing) facilities for disabled inpatients. 50% of the inpatient toilet/bathrooms are of poor standard + some frankly unhygienic. The refurbished ones are lovely. in February your kitchen ran out of kosher food. Your healthcare assistants do not care enough about whether a patient is fed; can eat unaided; can open food package; have fresh water or other fluids if recommended by dr. There are shortages of pillows. linen comes back from laundry with old dressings and excrement still on it.*"

So it is disappointing when a complainant writes

"*Although promises were made that care and services would improve directly resulting from our complaint there has been no follow-up and no way of my knowing whether the promises made were in fact put in place. Since my complaint, another incident of neglect was experienced by another member of my family. However a complaint was not made because we felt it would not make any difference at all. I would avoid using (this hospital) in future.*"

The complaint system has to plug into the quality improvement system and the positive results of this have to be made clear to all. Customer quotes and anecdotes are very useful to dramatise and sharpen the statistics.

This is a recipe for action that leads us away from the cynicism that says that the causes of complaints are known and will never change. The hardy annuals driving complaints in this hospital were the same as everywhere else "medical care; nursing care; staff attitude and communication with the patient" (hospital complaint report). Some of this is clinical stuff and our survey steered well clear of exploring this. We were interested in process and only needed to know about these clinical matters in the context of what prompted the complaint.

Identifying the Wins

However behind those big broad headings lie lots of little actions that may have contributed to failure. If people complained about 'hospital appointments staff gave wrong information', what is going on here? What is happening to make those people who said they had a problem with 'getting sent home too early?' What is the connection of this problem to those who mentioned 'arrangements for leaving hospital were poorly handled'. There is a lot to unpack, define and act upon.

Good Letter - Poor Outcome

Hearing about what has happened as a result of the complaint will help to reassure the complainant. Of course the news will often come some time after the complaint. What may help more at the time is to make the actual process of complaint investigation more visible to the complainant. What happens after a complaint is escalated to the complaints department and is taken into the formal system is invisible and unknown to the complainant. Even if the quality of the letter is acknowledged as high - "prompt and clear", it may not be enough to retrieve the situation

"*Although the response to my letter of complaint was prompt and clear and also apologetic about the substandard care I received, my confidence (in the hospital) remains much lower than it was prior to the incident that led to my complaint. I suppose that I am not certain that another patient might not experience similarly poor care despite the assurances given in the response letter. However I cannot really fault this final letter.*"

At the time of the survey, the complaints department was called the complaints and legal services department. As one user commented

"*In addition I find it very annoying that when you ring the complaints + legal services department (couldn't the dealing of complaints have a more user friendly title or separate the two titles it comes across as very intimidating + believe me I'm not easily intimidated)! You're told quite curtly to write a letter. What if you have difficulty writing for various reasons. Surely complainants could be facilitated to use other means . P.S. The food .. is still in my opinion absolutely despicable - when is going to be better?*"

Rich and detailed communications

The PS gives the authentic flavour of the complainant communication - the sheer generosity and variety of its insights, veering from corporate nomenclature to the nature of the complaints process and then straight on to the quality of food. It is a reminder of the richness of this seam as well as the difficulties in analysing and transposing this information which never arrives in neatly packaged bytes of data.

Early Solutions and Avoiding Escalation

We have discussed the costs of escalation and the survey showed up an aspect of complainants' behaviour that offers a chance to avoid the escalated complaint. The survey shows that there are many opportunities to intervene and discuss matters at the front line. When asked whether they had talked to anyone about their most serious problem before coming to the Complaints Department, over three quarters said they had. A few had gone to sources outside the hospital such as a solicitor or the Minister of Health and their MP but for the most part, they went to someone in the hospital. The hospital has a chance of pulling the complainant back from the formal procedure. Most of the people who answered this question said they had contacted someone at least twice and a few, up to three times. How can these opportunities be better used?

Early Complainant Connection

Even if that opportunity is missed and a complaint is subsequently received by the complaints office, we recommended an early meeting which would give the respective parties an opportunity to voice and to hear the feelings and connect with the experience and the person bringing the complaint - relative, carer, patient. This 'complainant connection' meeting would reveal and explain process, would manage expectation and might even resolve the issue. By contrast, the meeting offered at the end of the process may appear to the complainant as an over-whelming, quasi-judicial environment where a verdict is pronounced.

IV. Understanding the Complete Picture

Beyond Satisfaction - Other measures of the result

So what about satisfaction? We in fact think that the satisfaction rating in the context of the escalated complaint is not in itself a particularly informative indicator of what is going on. The output from a survey of this sort has to be action - and I do not mean ritual disembowelment of the complaint manager. More positively, managers need to have data (it may need supplementing) that will lead to process or attitudinal improvements to the work of the hospital or the complaint office itself. Secondly they need a measure or as I will argue a group of measures to see if improvements in the system have worked.

So we use a set of measures looking at 'confidence' and 'readiness to recommend' to complement the single satisfaction question. We also like to know about the impact of this experience as reflected in the complainant's conversations about it to others - the word of mouth phenomenon.

Almost half of the people we surveyed will tell between 6 and 15 people about their experience. Most reported that their confidence in the hospital had gone down. The experience had not raised the confidence of any complainant. It dissatisfied almost two thirds of the complainants and a minority were taking it further. Others while not satisfied, were letting the matter drop quoting reasons such as

"*I did not take the matter any further as i waited weeks and weeks for a reply and when it came it was full of medical jargon*"

The 20% level of satisfaction with the response that we recorded, while not unexpected since we are dealing with a formal escalated process, is still disappointing. However it must be seen against another finding - that whatever the low level of satisfaction and the drop in confidence in the institution, well over half of the sample surveyed would recommend others to take their complaint to the hospital. Part of this of course is because they have no choice - if they do want complain, there is no one else to take it to. Another clue may lie in what we discussed at the beginning of the article - the sheer emotional charge that led to the complaint in the first place. The complainant will tell others not to be put off by the system but to have their say.

Understanding the Complete Picture

Escalated complaint processes are usually marked low for satisfaction. This may depress managers but more importantly, put them off doing more surveys. They are not masochists - why do a survey when you know people are pissed off? The solution to this is to get data that tells the story of all users - the satisfied and the dissatisfied.

When trying to understand how well an organisation is dealing with its customers, we need to have information on all of them, namely

- % of users who had no problems with their experience of the hospital
- % of users with problems who did not mention them to anyone
- % of users who mentioned a problem to someone and were satisfied
- % of users who mentioned a problem and were dissatisfied but did not escalate it beyond the front line

In addition, a survey of all staff involved in complaints to compare is very informative and one way to use the data is to contrast the two views - internal and external (i.e. the complainant) - of the system. A workshop on closing that perception gap is always a lively debate and switches the emphasis from contemplating problems which appear intractable to deepening understanding and focussing on solutions.

This holistic approach moves the emphasis from the performance of one small part of the system - where the problem has been congealed and frozen into the shape of a formal complaint - to a fuller understanding of what happens to the individual.

At this point, we have an approach which can be demonstrated as essential management information where there are no victims and villains but only winners.

The M-A-C Call for Action

We say - don't be scared of dissatisfaction research. Look behind the 'satisfaction/ dissatisfaction' measure at the full range of problems that may spark dissatisfaction as well the whole process and all the people potentially involved. Discover the smaller wins that will over time change attitudes and address the hardy annuals. This learning is not punitive but restorative both to staff and patient alike. Understanding the emotions on both sides of the house will help avoid burn-out and increase co-operation and participation amongst all. In this way we can begin to work with those general criteria mentioned by the Ombudsman - **openness and learning: monitoring and performance - well connected with clinical governance and quality improvement activity.**

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