Harnessing the power of language to enhance patient experience of the NHS complaint journey in Northern Ireland: a mixed-methods study

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Disclaimer: This report contains transcripts of interviews conducted in the course of the research and contains language that may offend some readers.

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Scientific summary

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Scientific summary

Background

Effective complaint handling is vital to a safe, high-quality healthcare system, yet recent reports still highlight major failings with the current complaints system in the NHS. While effective complaint handling is recognised as contributing to quality improvement and patient safety, poor complaint outcomes lead to litigation, at significant cost to the individual complainant, the complained-about healthcare staff and the NHS as an organisation. The strongest predictor of litigation, however, is not medical error or patient demographics but dissatisfaction with communication, either within the clinical encounter or subsequently in the complaint-handling process. A challenge in addressing litigation rates is therefore to develop effective communication interventions for healthcare complaints handling. NHS complaints policies, however, focus mostly on systems and procedures and prioritise administrative and quantitative key performance indicators over qualitative outcomes relating to complainant experience and quality improvement.

A recent systematic review points to a recognised need for patient-centric ways of responding to complaints in order to improve complainant satisfaction, in relation to both the formal written response and the spoken communication skills of complaint handlers (CHs), and to a lack of training resources to meet this need. However, although relevant communication goals for improved complaint handling are frequently identified (e.g. apology, empathy, understanding), they are often not met because there is insufficient understanding of how to achieve those goals when responding to a complaint. Observational analysis of moments of interactional contact has been neglected in previous attempts to reform the complaints process and is likely to improve our understanding of the components of good and poor communicative practice. The primary aim of this study was thus to focus the analytical lens on the lived experience of complainants going through NHS complaints procedures, using the observational methods of conversation analysis (CA) and discourse analysis (DA) to examine in detail the language used in encounters (both spoken and written) between complainants and NHS staff in order to understand how to meet the recognised need for patient-centric, comprehensive and bespoke ways of responding.

Objectives

Our study thus aimed to address the following research question:

How can the power of language be harnessed to transform complainants' experience of complaining in the NHS and reduce their recourse to litigation?

This was addressed through six research objectives:

1. to examine complainants' lived experience of interacting with the 'system' through detailed micro-analysis of direct communications, both spoken and written, with NHS representatives
2. to audit patients' perceptions of cultural bias in NHS contexts and show how this may create patterns of social relations that can help or hinder effective complaint resolution
3. to record self-reported expectations and experiences of the complaints journey and its timeline, focusing on evolving perceptions of the complaints experience and the complained-about issue, and the impact of the process on complainant well-being and satisfaction
4. to identify and cross-reference moments of change and key drivers of change in complainants' responses and intentions (including intentions to litigate) throughout their complaints journey
5. to develop an evidence-based 'Real Complaints' communication training resource to provide effective, evidence-based intervention that addresses the specific interactional and interpersonal challenges of NHS complaints handling

6. to disseminate good-practice recommendations to service users, NHS staff, local and national policy-makers and ombudsmen that will improve NHS complaint-handling processes and experiences.

Methods

Our study developed an innovative mixed-methods design with multiple data sets. The wider institutional culture of the NHS was examined using a cultural audit tool to assess service-user perceptions of the institutional context within which complaints take place. The core of the project was the microanalysis of language-in-use in both spoken and written communication between complainants and the NHS Trusts and a parallel analysis of participants' subjective reflections on their complaint journey, both during and after that journey. This mixed data approach constitutes a detailed, contextualised examination of the relationship between complainants' observable complaint-handling experiences and their personal, evolving perspective on both the complaint issue(s) and the complaints process.

Data

The project was conducted across three data-collection sites: complaints services from two Health and Social Care Northern Ireland Trusts and one Patient Advocacy Service providing support to patients making a complaint.

The cultural audit generated 115 service-user responses providing data on the degree of congruence/dissonance between patient expectations and experience in the NHS. For the other data strands, a total of 80 active complainants were recruited, of whom 23 consented to longitudinal participation. The observational data comprised recorded phone calls, meetings or written correspondence (letters and e-mails). These data were structured in two key data sets: initial encounters (by telephone or by e-mail) and longitudinal case studies which followed individual complainants through their entire complaint journey. The observational data in the longitudinal case studies were complemented by a parallel qualitative data set of participant diaries and semistructured interviews with each of the longitudinal participants in order to cross-reference the findings of the observational analysis with participant appraisal of their complaints experience.

This yielded a data set of 23 complaint journeys and 86 phone calls (1155 minutes), 113 written communications and 6 recorded meetings as well as 36 participant diaries, 23 interviews and 115 cultural audit responses collected over a period of 24 months.

Analysis

The initial cultural audit provided a baseline view of the wider organisational culture within the NHS. It applied a validated measurement tool to assess the relative influence of cultural perspectives on four key aspects of respondents' relational expectations and experiences within the NHS: 'courtesy and respect'; 'how knowledge is valued'; 'how fairness and equity issues are resolved'; and 'how voice is expressed'. In this way, the cultural audit provided insights into the sociopolitical context of the patient–healthcare provider relationship within which these complaint journeys were taking place.

Given the focus on communication, the application of CA to the spoken (mostly telephone) interactions between complainants and CHs provides the central focus of the project. CA is a form of observational research that studies in fine-grained detail how participants in conversation methodically display their understanding of each other's turns at talk and how those understandings are negotiated in interaction. CA thus involves turn-by-turn analysis of communication practices in context to understand what

matters to speakers moment-by-moment in the interaction and to reveal the impact of particular language choices on the ongoing conversation. In this way the 'next turn proof procedure' of CA reveals the effectiveness (or otherwise) of individual interactional practices to provide a robust evidence base for the development of bespoke communication training resources based on real interactions. Similarly, DA is a linguistic approach to the analysis of written texts, which focuses on the meanings, intentions, ideologies and consequences of particular language choices by the writer, and views discourse as a form of social action or practice. The written communication in our observational data set was analysed focusing on choices in grammar, word choice and pragmatic meaning (what is implied or presupposed), to provide an empirically grounded account of good and poor communication. The analysis of the observational data in each of our longitudinal case studies was supplemented by detailed thematic analysis of participant diaries and interview data for a more holistic account of the key factors both within cases and between cases. An iterative process of open coding, informed by the findings from the cultural audit and the microanalysis of the observational data, was applied across all data sources for each individual journey to uncover central themes and detect inconsistencies across various sources. These themes were subsequently categorised into two primary axes, 'process' and 'c-concepts' (causes, consequences, correlations, constraints), for the analysis of longitudinal case studies. The cumulative effects of multiple encounters in an overall complaint journey were examined to provide a deeper understanding of the relationship between the personal and the systemic.

Results

Our longitudinal analysis illuminates the dual nature of complaints: as personal expressions of dissatisfaction with care experiences and as systemic critiques. Understanding this duality – complaint and care – is vital to improving the complaint-resolution process by ensuring both the validation of individual lived experiences and effective systemic response. Complaining is experienced as a dynamic journey with evolving narratives reflecting complainants' shifting perceptions, expectations and experiences of the 'system'. Each interaction within the journey moulds these perceptions and future expectations, hence the paramount importance lies in improving individual instances and enhancing connectivity throughout the complaint journey, as each next encounter can 'overwrite' the effects of the previous. Written responses, in particular, were often noted to have the greatest negative impact on the overall evaluation of the journey by not acknowledging accountability, providing insincere apologies, using obscure medical jargon, undermining complainants' accounts of events and detailing irrelevant patient histories. These longitudinal findings were also reflected in the analysis of the cultural-institutional context (cultural audit), which found significant gaps between patient expectations and experience around assessment of the 'system' as overly hierarchical and insufficiently egalitarian, as well as lacking in recognition of individuality, leading to expressions of fatalism in patient expectations.

Across all data sets, complainants convey three key interrelated interpersonal priorities which are evident in how they communicate their complaint and the expectations they place on call-handler responses. Complainants want to tell their story in full; they present their complaints not as a collection of facts, but as a detailed narrative which stresses the impact of their story on their daily lives. Relatedly, complainants want to feel that they have been listened to and that their perspective (including the lifeworld impact of the complained-about event) has been fully recognised. Finally and most significantly, complainants seek ratification of the reasonableness of their complaint and/or of their identity as a reasonable complainant. The CA concept of affiliation (designing responses to display recognition and validation of the stance expressed by the other speaker) was identified as a key conversational skill required to meet complainants' interpersonal priorities in the moment-by-moment communication of a complaints encounter. Specific forms of affiliation and cues for affiliation emerged as important for effective and efficient complaints handling. A key finding, for example, was that affiliation specifically to the 'reasonableness' of a complainant could be deployed to negotiate explicit blaming without agreeing or disagreeing with the blame. Crucially, our interactional analysis also showed that the absence of relevant forms of affiliation typically led to escalation of the scope, scale and emotional intensity of the

complaint. Similarly, the absence of affiliation and ratification in written responses was found to lead to dissatisfaction with the complaint and, in some cases, escalation to the Ombudsman or to legal redress.

The Real Complaints Training package was developed around the research findings relating to the significant role of specific forms of affiliation for healthcare complaints handling. The training package is composed of a number of modules which address a series of skills: ways of listening, identifying complainant cues, using affiliation to meet complainants' needs and negotiating the expression of explicit blame. Several training design workshops and evaluation workshops were held with complaint-handling teams to refine the training design and ensure useability and accessibility. A key outcome of those workshops was the flexible modular design of the training resources that ensures that the materials can be adjusted to meet training needs and accommodate practical constraints on delivery. The design also ensures that the training can be adapted to complement existing training approaches. Additionally, guidance on how to compose written responses to complaints, what to include, what to avoid, and ideal ways of ensuring that the complainant feels their complaint has been listened to and taken seriously are included in this report.

Conclusions

Our study found that the highest priority for complainants is to be seen as reasonable complainants and for their complaint to be seen as 'reasonable' and legitimate. At a more systemic level, complainants seek concrete and measurable change and reform as validation of the reasonableness of their complaint. Addressing the gaps between complainants' expectation and experience requires a more person-centred approach in which the complainant's perspective and reasoning are reflected and the lifeworld impact of their complaint is demonstrably understood. Current practice is variable but where dissatisfaction with the complaint process is expressed, it is usually related to a perception that the complaint has not been adequately affiliated to. Affiliation in various forms (affiliation to emotion, to complainability and to reason) demonstrates that the CH is aligned with the objectives of the complainant and willing to address the complaint's detail and complexity. Our research has led to the development of guidance and training that will assist complaint-handling staff in navigating these interactions. This offers strategies to validate the complainant's experiences and emotions, while also maintaining professionalism and fairness throughout the process. By adopting a person-centred approach that acknowledges and supports the complainant's need to be seen as reasonable, organisations can enhance complainant satisfaction, contributing to a more constructive and collaborative relationship between NHS and patient.

Study registration

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