

Creating the right environment for individual complaints resolution

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Jon Wigmore explains some ways in which the NHS can help individuals to achieve resolution of their complaints.

Perhaps the Hippocratic principle "First, do no harm" should be extended to complaints management. Like doctoring, the discipline is inherently hazardous. An intervention that will reduce one person's inflammation will provoke apoplexy or an allergic reaction in another. People's dealings with the hospital can feel like a deliberate series of affronts.

Of course, time and care taken by complaints staff to communicate can break this pattern, for a while at least. But in the NHS we don't have gift vouchers to hand out like our complaints-handling colleagues in the private sector. If the NHS is unable to deliver through the whole process – a journey that involves a far greater cast of characters than the complaints team – complaints management becomes an empty exercise.

Our approach at Guy's and St Thomas' to "First, do no harm" is based on trying to understand what resolution means to individuals. We then aim to create an environment where people have a chance of finding resolution, at least as far as the questions, fears, suggestions and criticisms that they bring to us are concerned. Our philosophy is that the experience of illness and incapacity is painful enough for patients and their loved ones without having to face an impersonal, defensive and unyielding institution.

But complaints staff are working in the troubled area in healthcare between rhetoric and reality, expectation and experience. People increasingly approach us with the assumption that we are here to lie, and that we are well versed in the art of that apocryphal NHS activity – the "cover-up". In fact, most of us feel anything but covered up.

So where to begin in a discipline with no typology, diagnostic guide or anything even resembling an evidence base?

Volume versus the individual

The single most important message is that one size does not fit all. You know this, of course, but you also have to balance the demands of a volume operation with the individual needs of the people who wish to make a complaint. Many do not know what outcome they seek from their complaint but are very tuned into what they do *not* want to be told. Better basic customer care will lessen the likelihood of the handling of the complaint becoming part of a larger complaint. Any of us who have acted on a failure of service want to:

- know the name of the person handling our case and be able to get hold of them quickly;

- know that we will be treated fairly;
- be kept informed, with a fast response to queries;
- feel that the complaints department has influence; and
- be made to feel that the problem is not us, but what has happened to us.

If these basic processes are working well, some of the guesswork will be taken out of the next stage – the grading process – because signals that the standard approach cannot work for someone will have been picked up. An important reason to grade complaints is to identify people most at risk of being hurt by the complaints process itself. This includes:

- people whom investigation suggests the hospital has avoidably hurt;
- anyone who has been bereaved, particularly when the death has not been expected or accepted (there is surely a book waiting to be written on bereavement and complaining);
- people whose experience (often of indignity and suffering) has been missed, dismissed, ignored or not accepted by the hospital; and
- people who are afraid that they will receive a worse service due to complaining.

Having identified the people least likely to absorb any additional shocks the complaints system may bring, we then need to adjust our systems for them. Although we cannot change the content of the "bottom line" in complaint responses – the factual message about why we think things happened the way they did – we do have influence over how that message is communicated. We can also make sure from the outset that we are answering the right questions.

Engaging with complainants

Those taking an engagement approach attempt to understand, and to some extent help, the complainant to decide what a desirable outcome through the complaints process will amount to. Most of us will at some time have recited the litany of things that are not available to complainants – cash, being informed of disciplinary action they have triggered, or being told about similar incidents or people in the same boat. Presented crudely, this kind of advice will feed feelings of powerlessness and stimulate that part in most of us who have seriously complained that seeks revenge.

Instead, offer choices at every possible opportunity, particularly at the acknowledgement stage. If a cue is offered that personal contact

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would be welcome, for example through the suggestion of an early meeting, or the provision of a telephone number or email address, then take it. Introduce yourself, check your understanding of what is being said and asked for, and explain the system. Emphasise that a choice made at the outset by the complainant does not determine the remainder of the process.

Sometimes things have gone so wrong for people that you have to pick up the telephone immediately and talk to them. I read a letter from an ex-nurse, seven days after she had undergone surgery for an aneurysm, who had been decanted from a broken-down ambulance at 1am to relieve herself on the side of a dual carriageway in Kent one cold February night. I rang her in part to comment on the restraint she had shown in choosing the words to use in her letter. In fact, the letter did not even tell the whole tale. Her husband had also virtually been escorted from hospital premises when trying to help her at the beginning of her disastrous experience. To avoid any further problems, the complaints office became a hotline for this couple when further misunderstandings arose. Perhaps one "gift voucher" that we can offer in the NHS is to remove obstacles for people that to them feel insurmountable.

The meeting: a powerful tool

The most powerful tool for entrenching a complaint for staff and patients alike is the meeting, but it is also here where we are best placed to give back some power to complainants and, through that, create an environment where resolution is possible. Based on my own experiences of messing up meetings, I am well placed to advise my colleagues on how to do the same (see box).

Complainants, too, can make meetings hard to organise. Some will push for a grand, courtroom-style showdown, while complaining about the length of time it is taking to set it up. All we can do is offer them choices: a larger meeting in three months or to meet available staff the next week and think again about outstanding questions.

Even when things seem to be going wrong, they can be salvageable in a meeting if staff are prepared to do three things:

- suspend their scientific impulse to classify the complainant;
- know when to show humility rather than expertise; and
- try to acknowledge what happened to the complainant.

The urge staff sometimes feel to imply criticism of complainants and colleagues in meetings will also entrench a complaint beyond any form of resolution.

From the heart

I was in a meeting some months ago where a man who had lost his wife to a savage cancer had returned to the hospital a year later, having obtained her medical notes. His fear that errors had occurred in her care was amplified by what he found in her notes, which included the usual bundle of revised drug charts and care and treatment plans. As a carer he had been devoted to his wife, hypervigilant and tricky to have on the ward. He arrived 20 minutes early, during the pre-meet, bristling with anger and suspicion. A tense half-hour of accusation and explanation followed.

A difficult discussion began about the decision not to scan his wife, whom I will call Rachel Wheeler, towards the end of her life. The oncologist who had made that decision then said:

"I remember Rachel very well, and everything you did for her. You were there night and day. It was hard for us because we could do so little to fight the disease and although we didn't expect a cure, we were taken aback by its speed of progression. But every time I

HOW TO MESS UP A MEETING

- Take three months to organise it.
Because staff time is far more precious than patients' time.
- Don't agree an agenda in advance.
Better still, impose your one on the complainant.
- Ensure that involved staff do not attend.
Allow them to slip out of range or – in the case of junior doctors – to be protected by their consultant.
- Ensure that senior staff new to the complaint are not briefed.
At least one person present should ask the complainant, ideally several months into the complaint, what the problem is.
- Don't tell the complainant who will be there or why they will be there.
Instead say: "The head of nursing is here to support the sister" (implying the complainant is going to bite them).
- Make sure no-one apologises.
- Afterwards, rework contentious discussions in the meeting record and send the record to the patient three months later without an offer to incorporate their comments.

make a decision about offering a scan to a patient I will remember Rachel Wheeler and our discussion today. I can see how hard it has been for you to come back but it has been very important to us that you did. Thank you so much for coming in to see us."

This statement showed Mr Wheeler that staff remembered and respected his wife and that she and he had made an impression on a system that had felt impersonal. The acknowledgement that coming into the building where his wife had died was not easy for Mr Wheeler, and signified something in itself, pushed all of us out of our defensive/expert modes and into silence. This is about looking someone in the eye and speaking from the heart, and being willing to listen and learn.

Ways toward individual resolution

In another case, I received a 48-page diary about a three-month hospital stay from a very senior retired soldier, which read like a chronicle of forced detention. The complainant offered to help us resolve matters. We therefore offered him a draft of our complaint investigation for comment, having agreed with him those parts that were important to investigate. He made some suggestions, but broadly endorsed our approach. He wanted to know his story had been heard and that systems experienced by patients – and, incidentally, staff as well – as inflexible, overpowering and inefficient could be receptive to change.

In a complex and distressing case last year we made a detailed investigation into the treatment of an elderly patient, who had died shortly after discharge. Four months later, the patient's daughter wrote expressing a lingering doubt about whether practice had changed. This was resolved by a visit to the ward where care had fallen particularly short of expectations. Its staff's awareness of her case and determination that change would continue was communicated face to face in a way that no letter or independent review could accomplish.

The structure of the NHS complaints procedure can, if allowed to become the end rather than the means, be inimical to resolution and individual responses. In extreme cases, we fail in our aim to do no harm as our complaint-handling recreates the frustration and powerlessness described in the original complaint. I hope that we will see the focus in our sector moving away from defensive self-justifying documents and towards discovering and creating the conditions for individual resolution – at least in those cases where it really matters. HARRIS