

ORIGINAL PRACTICE DEVELOPMENT AND RESEARCH

From transformative learning to social change? Using action research to explore and improve informal complaints management in an NHS trust

Anki Odelius*, Helen Allan, Billie Hunter, Karen Bryan, Wendy Knibb, Jill Shawe

*Corresponding author: University of Surrey, Guildford, UK
Email: ann-christine.odelius@surrey.ac.uk

Abstract

Background: The number of complaints from patients and/or carers concerning aspects of care has increased over time. Yet, in spite of a growing body of national and international literature on healthcare complaints, there is a lack of knowledge around how nurses and midwives manage informal complaints at ward level, or staff needs in relation to this.

Aim: Using an action research approach with mixed methods, four phases and four cycles, the aim was to explore informal complaints management by nurses and midwives at ward level. We discuss the action research process primarily in connection with learning and service change, drawing from the qualitative data in this paper.

Findings: The analysis of the collected qualitative data resulted in three main themes, related to the complexities of complaints and complaints management, staff support needs and the existing ambiguous complaints systems, which are hard for staff and service users to negotiate. The action research approach facilitated learning and change in participants in relation to complaints management, in the collaborating trust.

Conclusions: The extant body of research on complaints does not sufficiently recognise the complexity of complaints and informal complaints management, or the complaints systems that are in place. Needs-based staff training can help support staff to manage informal complaints more effectively.

Implications for practice:

- There needs to be recognition of the complexities involved in complaints management
- Complaints systems need to be clearer for the benefit of service users and staff
- Staff need training and support that is tailored to their needs to improve their response to complaints, leading to a better patient experience
- Limited interventions, informed by staff needs, can lead to change and act as a catalyst for a wider change in informal complaints management

Keywords: Action research, transformative learning, social change, healthcare complaints, patient complaints

Introduction

We have previously published a critical reflection on practice development in this journal relative to an earlier stage of the RESPONSE project (Responding Effectively to Service users' and Practitioners' perspectives On care concerns: developing Sustainable responses through collaborative Educational

action research), which explores how nurses and midwives manage informal complaints at ward level in a UK NHS trust, using action research (Odelius et al., 2012). The paper debates the challenges involved in using action research methodology, drawing on transformative learning theory (Mezirow, 1997), and how these challenges, primarily those concerning [sustained] participation, were addressed at the early stages of the project.

With the project now completed, this paper draws on the qualitative data from the study to discuss how the action research approach and findings have contributed to practice development. We will focus the discussion on change as a key action research concept, using our action research project conducted in a complex healthcare context, and drawing on transformative learning theory and the concept of social change. Detailed findings from the RESPONSE project are discussed elsewhere (Allan et al., 2015a; Allan et al., 2015b).

The RESPONSE project was based on identified priorities around the provision of quality services delivered by nursing and midwifery staff, focusing on informal complaints management and communication. This was in response to an increasing number of complaints from patients and/or carers related to aspects of care, a significant number of which concerned poor communication and attitude involving healthcare staff (Sidgewick, 2006; The Information Centre for Health and Social Care, 2011, 2012, 2013, 2014). Frontline staff such as nurses and midwives are often the first to be approached by patients or carers with concerns or informal complaints (Parliamentary and Health Service Ombudsman, 2010). However, little is known about how nurses and midwives manage complaints at ward level in spite of a growing body of research on healthcare complaints (for example, Anderson et al., 2001; Montini et al., 2008; Hsieh, 2010, 2012; Clwyd and Hart, 2013; Tingle, 2014; Treanor, 2014). The Health Professions Council report (2008) that literature related to healthcare complaints from a UK perspective can be divided into three main themes:

- Service user dissatisfaction
- Litigation
- Complaints processes

Complaints processes form the biggest part of the body of literature. This is largely consistent with the literature review conducted to contextualise the present project, although our literature search also showed that there are often largely unsupported connections made between complaints and improved healthcare in the literature, which is discussed later.

An action research approach (see later) with mixed methods provided a useful springboard to explore issues surrounding informal complaints management by nurses and midwives. In particular, the qualitative methods we present in this paper facilitated an in-depth exploration of this previously under-researched area.

We start with an overview of the ideas underpinning action research, transformative learning and social change, and discuss these in relation to our project. We then define our methods, findings and action research process before the discussion, concluding remarks and implications for practice.

Action research, transformative learning and social change

Action research has its roots in social psychology through Kurt Lewin and his well-known work on group dynamics, or 'group life', and social change (Lewin, 1947, p 8). He pursued the idea that those who would/could be affected by change should be involved in the process itself to ensure that the change is effective and grounded in practice.

Action research methodology, also described in the previous paper (Odelius et al., 2012), has traditionally been employed in organisational development contexts and is now commonly used within health and social care (Bradbury Huang, 2010). It is increasingly regarded as useful in nursing

because it promotes the embedding of insight, learning and research findings in practice, and so aids practice development (Holter and Schwartz-Barcott, 1993). Action research cannot easily be described or defined and is best referred to as an approach (Meyer, 2000) or an orientation:

Action research is an orientation to knowledge creation that arises in a context of practice and requires researchers to work with practitioners. Unlike conventional social science, its purpose is not primarily or solely to understand social arrangements, but also to effect desired change as a path to generating knowledge and empowering stakeholders (Bradbury Huang, 2010 p 93).

It is clear in the above quote that change is central to action research, and that change is anticipated to take place in different ways, for example, in relation to learning and empowerment. It is also clear that understanding and action are interlinked (cf. Thomas and Thomas, 1928; Merton, 1968; Brown, 1989).

Alongside change, other pillars of action research are participation and equality (Bradbury Huang, 2010), while (Hilsen, 2006) sees the action research process as a democratic way of working. It is also expected to induce empowerment of the participants (Snoeren et al., 2011); this is also evident in the above quote from Bradbury Huang. The action research process is cyclic, relies on reflexivity and traditionally involves interventions of some description although this is not strictly necessary (Waterman et al., 2001).

Increasingly, an affinity between action research and transformative learning theory has been recognised because the two share the core underpinnings of change, reflection and action (Gravett, 2004; Taylor, 2007).

Transformative learning theory, used as the framework in our previous paper (Odelius et al., 2012) has emerged in recent decades in adult learning to support the development of teaching in higher education, and extended to other fields (Taylor, 2007). It is based on the ideas of Jack Mezirow (1997), who saw learning as a process of reflection and meaning making, leading to increased understanding and change. We discussed in our earlier paper how transformative learning in our project took place on individual, NHS trust and research organisation levels; and also the importance of support at senior management level to implementation and sustained change throughout the trust.

Problems with healthcare complaints management exist nationally and globally (Anderson et al., 2001; Montini et al., 2008; Hsieh, 2010, 2012; Clwyd and Hart, 2013; Tingle, 2014; Treanor, 2014) and therefore research in this area is likely to be of interest to the wider research community. Nevertheless, since action research and transformative learning promote change through individual learning and learning in groups and organisations of limited sizes, such as NHS trusts, it could be questioned if this learning and change can ever translate to, and be useful for a bigger audience, and how it can be translated and implemented. Learning also takes place in specific contexts perhaps imbued with particular cultural values that are not easily translated. Indeed, Mezirow's ideas have been critiqued for not sufficiently taking into consideration the context and its role in transformative learning (Levine and Scott Tindale, 2015).

'Social change' is frequently claimed to be the ultimate aim for conducting action research in the related body of literature although it is rarely enlarged on what this means. Instead, it seems to be taken for granted that this is what can be achieved by action research. Coulter argues that the value of action research in educational contexts is often expressed ambiguously by the use of 'murky' and sweeping claims by researchers, (Coulter, 2002b, p 189) and it could be posited that this also applies to other areas of research, such as nursing. Conversely, it could be argued that due to the innate complexity of action research and the often complex issues researchers use it to explore (Waterman et al., 2001), it may not be possible to be entirely clear about aims before commencing the research process – particularly since the focus of a project can shift during the research. This is also one of the

particular strengths of action research, which can lead to unexpected and useful findings (cf. Bridges and Meyer, 2007 on this). If the research concerns issues of potential interest to a wider audience, however, it could be beneficial for researchers to reflect on the anticipated scope of change given its centrality in action research.

Social change, although frequently referred to as an aim, implies a wider impact than that normally associated with action research, which encompasses individual/local learning and change in particular environments. Although it is expected that findings from locally based action research projects are also disseminated more widely (Meyer, 2000), this is not the same as wider social change. That is, discussions of findings from action research rarely move beyond the immediate context of the research and 'action researchers can do more to develop post-intervention insights' (Bradbury Huang, 2010, p 105). Social change, by definition, normally involves noteworthy changes to values and norms at a societal level over time. Pettit argues that action research promotes 'changes in knowledge, policy, and practice', which suggests a relatively wide scope, particularly since the author's interest appears to be in the area of 'global poverty and inequality' (Pettit, 2010, pp 820-821). However, Bradbury Huang, in the context of generalisability and validity of action research, asserts that there can also be a tension between a desire to keep up a well working local partnership and a desire to generalise findings (Bradbury Huang, 2010). In other words, researchers' wish to be able to generalise findings could affect how specific and useful findings ultimately are for the local collaborators, and it could also make the collaboration less democratic.

To generalise findings is, however, not strictly the same as a desire to widen the scope for change. It could be suggested that the former relates to a top-down approach to change and the latter means a bottom-up approach. Nevertheless, it is possible that both could affect the action research process and findings. Therefore social change, in its wider meaning, is a challenging concept in relation to a locally based project such as ours with a limited number of participants; although it could be expected that findings from an action research project 'can be relevant elsewhere' (Williamson et al., 2012, p 39). We did not reflect on the scope of the possible learning and change before or during the course of the project but simply set out to 'improve informal complaints management' in a general sense without detailing the meaning of this. To explore this further, we will use one influential theory from social psychology relating to social change.

Social change and influence is an umbrella term in social psychology, relating to how individuals and groups influence each other to instigate change. There are a number of theories relating to social change but one of the most influential theories is the minority influence concept (Moscovici et al., 1985), and this is the framework for the discussion in this paper. The reason for this choice is that the change we are discussing is the change experienced by a limited number of individuals in one NHS trust – that is a minority. We will reflect on the possible wider impact this could have using this framework.

Minority influence is mainly associated with Serge Moscovici and the work he and his colleagues began nearly 50 years ago (Moscovici and Lage, 1976; Moscovici et al., 1985; Levine and Scott Tindale, 2015). They challenged the then prevailing idea in this area of research that majority influence – the minority conforming to the majority – was to be taken for granted, instead positing that one or more individuals (a minority) could successfully influence a majority subject to certain conditions (Levine and Scott Tindale, 2015). Consistency is one of the conditions important in minority influence if it is to lead to wider social change (Moscovici et al., 1985). Their ideas were developed and critiqued for many years (Levine and Scott Tindale, 2015). One of their most influential developments of his theory holds that the perceived status of those who attempt to influence others plays an important role, regardless of whether or not they belong to a majority or minority (Tajfel, 1979; Turner, 1991).

Moscovici et al. (1985) proposed that influence is traditionally regarded as exercised by the majority on the minority, leading to conformity, and that influence has therefore been closely connected to the notion of power. They also stated that influence is based on conflict and that the inference is consensus; and that influence can mean minority influence as well as majority influence. Important factors to recognise in minority influence are consistency and flexibility; the assumption is that consistency on the part of a minority group would lead to a validation process, which in turn would lead to change in the majority group without it being aware of it. However, a minority cannot appear to be dogmatic in its quest for change and a flexible approach is needed to succeed.

To use the example of our project, the conflict would be the increasing number of healthcare-related complaints, perceived decreased patient satisfaction and the challenges staff experience in relation to this. Consensus would mean that the majority, that is most healthcare staff, would over time be able to accept the solution/values from the point of view of those members of staff who have, for instance, changed their understanding and approach to complaints management through communication training (communication training formed part of our action research process and this will be discussed later).

Eventually, according to this conflict theory, a social change or conversion would occur without the majority being directly aware of it happening. Turner also refers to this as indirect influence, or informational influence as opposed to normative influence (1991). Consistency, in other words, is key to minority influence and could in this case mean that there needs to be epistemological and ontological change, that is, a profound 'buy in' from the minority, and the learning internalised by individuals in order to influence others and foster a wider change.

Nevertheless an 'epistemological change' on a personal level may not be sufficient to change the status quo even at the local level if there is no systemic support in place (Taylor, 2007, p 186). Healthcare systems are complicated and politicised and therefore subject to recurrent policy changes that affect nursing and how nursing can be carried out by nurses (Traynor, 2013). This was also evident in our data and that, coupled with ongoing financial pressures faced by health systems such as the NHS, might realistically, limit the potential scope of change.

It may also be premature to talk about a wider change in values in relation to our project, given that we cannot know if the change achieved will be sustained in the individuals who participated in the project and communication training and who fed back that their views and behaviours had changed, or indeed if the change will extend to trust level.

Our discussion, however, does highlight issues in the wider dissemination and implementation of action research findings where researchers often claim to seek social change without elaborating on the meaning of this.

Issues of generalisation and transfer of knowledge and change in action research are shared generally with qualitative research, which is an area that has traditionally grappled with this. But it is not a given that quantitative research can be easily generalised or implemented either in spite of striving for this. In cross-cultural research, for example, researchers debate whether or not culturally specific knowledge or values are even possible to transfer across cultural boundaries (Opala and Boillot, 1996; Littlewood, 1998).

Methods, findings and the action research process

As previously stated, the RESPONSE project was initiated against the backdrop of a growing number of service user complaints in the NHS (Sidgewick, 2006; The Information Centre for Health and Social Care, 2011, 2012, 2013, 2014) and focused on informal complaints management and, initially, the role of communication in this context (Coulter, 2002a; Wong et al., 2007; Hsieh, 2010; The Information

Centre for Health and Social Care, 2014). The initial focus on communication shifted slightly in response to findings during the first phases and cycles, which are detailed later.

The project was undertaken between 2011 and 2014 in response to a local NHS trust approaching the research team to help explore how informal complaints at ward level to midwives and nurses could be responded to in order to improve patient experience. This remit informed decisions and processes throughout the project.

Action research is not a linear approach to research and there are a variety of orientations detailed in the literature. Ours is best described as a 'mutual collaboration approach', where 'the researcher and practitioners come together to identify potential problems, their underlying causes and possible interventions' and where changes normally do not extend beyond those who directly participate in the research (Holter and Schwartz-Barcott, 1993, p 301).

Our research findings can be explained in terms of different levels, where one level consists of analysis of actual collected data and another of the learning and change that took place among the participants throughout the project, which is not easily quantifiable. We also describe this learning in the earlier paper as taking place at both organisational and individual levels (Odelius et al., 2012).

We will discuss our action research approach, starting by outlining methods and findings drawn from the qualitative data, and then detail the process depicted in the diagram below, first published in Allan et al., 2015b (participation was discussed as an important action research cornerstone in the previous paper). We will then focus the discussion on change, using feedback from advanced communication training with midwives which was run during one action research cycle (see Allan et al., 2015a for a detailed discussion on this).

The project was essentially conducted in one NHS trust with complaints data collected from two further trusts during 2011-14. Overall, collected data for this mixed-methods project included NHS complaints data from trust databases, data from a series of midwifery reflective discussion groups, staff survey data (which will be reported elsewhere), feedback from a midwifery advanced communication training event, key stakeholder interviews, service user interviews and a nursing focus group.

Anonymised complaints data consisting of annotations of service user complaints from the period 1 January – 31 June 2011 were collected from three NHS trust databases as well as from a midwifery 'debriefing service' in the main trust, and these data were subjected to content analysis to categorise them (Graneheim and Lundman, 2004). Individual interviews with key stakeholders and service users, midwifery reflective discussion groups and the nursing focus group were recorded and transcribed verbatim prior to analysis in NVivo (QSR International, 2013). Coding took place within and between transcripts and also between groups by one researcher iteratively, using 'a general inductive approach' (Thomas, 2006, p 237). An initial coding scheme was developed and then discussed and revised by the research team, and also discussed and agreed by the action research group (see later). Three main themes were agreed on, which relate to the complex context of complaints, complaints management and difficulties for both service users and staff to understand and negotiate existing complaints systems. There is also need for staff support and needs-based training in relation to complaints management.

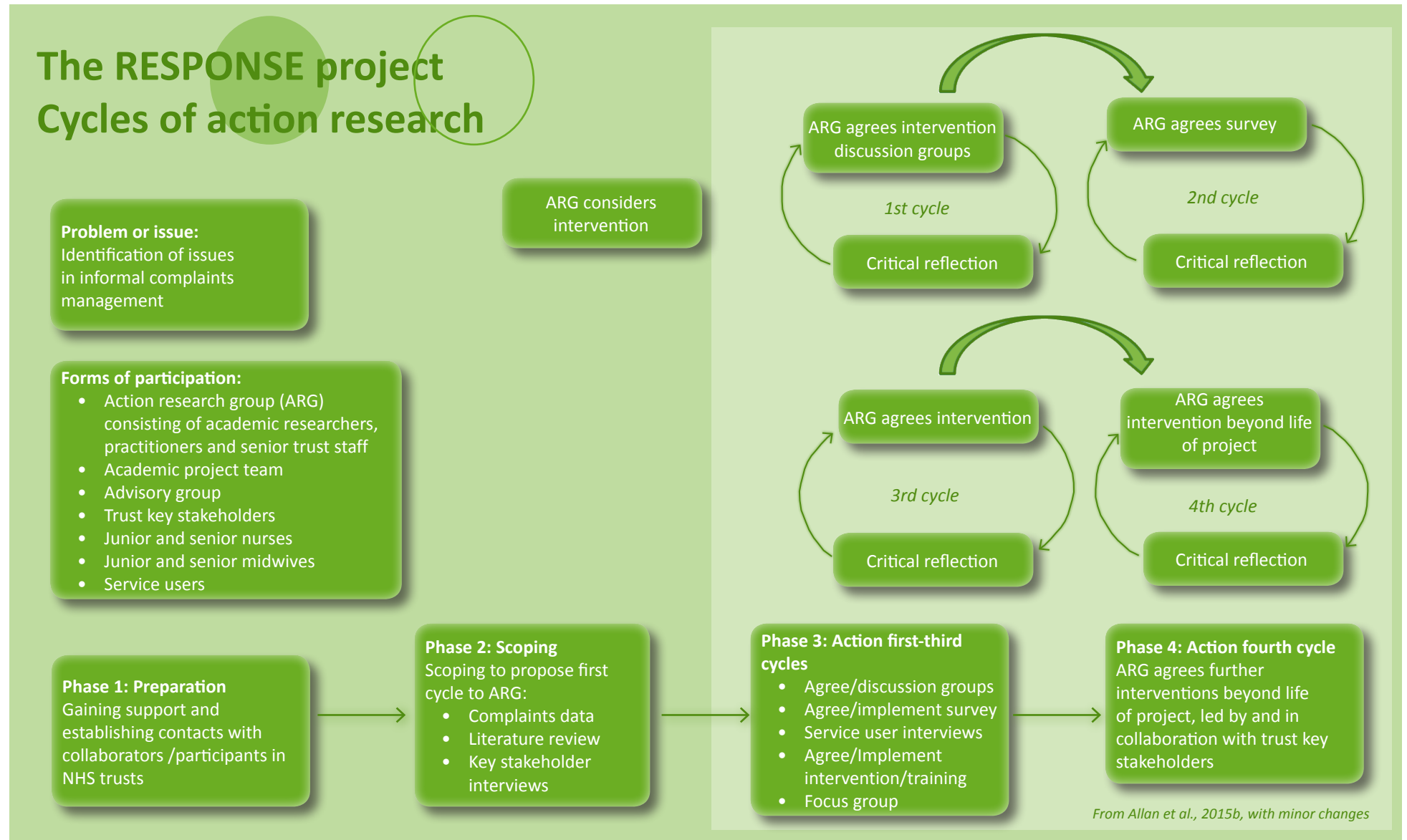
The action research approach also facilitated learning and change in participants in relation to complaints management and communication (discussed later), and with regard to the main issues in the collaborating trust around complaints management. In relation to the latter, some action research group members who were senior managers in the collaborating trust were privy to [anonymised] information such as analysed data, and they took part in the discussions and the development of the project. This led to insights about what was functioning well and less well relative to complaints management in their trust. This is evidenced in minutes from action research group meetings and email trails.

Following ethical review by the NHS and the University of Surrey, the preparatory phase saw the setting up of an action research group encompassing stakeholders from the collaborating trust and the research organisation representing varying interests to create a common ground and foster mutual trust – the ‘pre-reconnaissance’ phase (Snoeren and Frost, 2011, p 4). The group served as a conduit for reflection and decisions on interventions throughout the different cycles of the project. Phase two, the scoping phase, encompassed a literature review, in-depth interviews with key stakeholders from midwifery, nursing, teaching and learning, the complaints team and the Patient Advice and Liaison Service (PALS) in the collaborating trust (n=6). This phase also involved the collection and analysis of anonymised complaints data from two further NHS trusts, as well as from the collaborating trust. That trust also provided anonymised data from a separate database in relation to a midwifery ‘debriefing service’ where service users could reflect on aspects of their care post-delivery. The data collected during the second phase informed reflection and decisions by the group prior to phase three, which used three action research cycles involving, in the first instance, reflective discussion groups with midwives (n = 6). Eight one-hour audio-recorded discussion groups were conducted over nine months, facilitated by the first author of this paper. The intention was to recruit up to 40 midwives and nurses for the reflective discussion groups but due to recruitment issues also discussed in our previous paper, the group decided to go ahead with the small group of midwives only. The second cycle was decided on in response to the recruiting issues and consisted of a survey administered to midwifery and nursing staff in the collaborating trust, which will be reported elsewhere. For a third cycle it was decided to carry out communication training with midwives and an audio-recorded focus group with nurses. Further in-depth interviews were conducted with service users who had logged written complaints regarding aspects of their care or that of a family member (n=5). The fourth phase and the fourth cycle saw the group decide on interventions beyond the life of the project in the collaborating trust, consisting of further communication training for midwifery staff who had not participated in the training provided through the project.

The fourth and final phase, beyond the scope of the project, was initiated and organised by midwives who participated in the communication training run as part of the project, which is also discussed later. The nursing focus group was initiated and organised by action research group members who were key stakeholders from the trust, although it was conducted and the data analysed by the research team. These key stakeholders, as well as the research team, saw this as an important opportunity to explore the views of nurses in the trust, given that it had not been possible earlier in the project to recruit nurses.

Two phases and two cycles were initially planned for the project but in response to findings and through reflection, further phases and cycles were introduced by the action research group. This is consistent with action research, which can ‘be unpredictable’, and it is often not possible to foresee how a project will evolve (Bridges and Meyer, 2007, p 391). The difficulty can also complicate the ethical approval process if researchers and ethics committees having competing views on what research means, although ethics committees are becoming increasingly familiar with the action research paradigm, which should make the process easier in the future (Gelling and Munn-Giddings, 2011). In view of this, following the initial ethical approval, the research team kept in regular contact with the ethics committees throughout the research process to ensure that ethical guidelines for research were adhered to.

Figure 1: The RESPONSE project



The role of communication in complaints and complaints management was an initial area of focus for us and remained an important theme as we had anticipated. However, through reflection we came to realise that communication forms part of the generally complicated background of complaints and complaints management. A background where, for instance, single complaints often comprise multiple issues relating to different members of staff, often played out against an emotionally charged background and also informed by previous experiences. These types of complaints are common and very difficult to address for the midwives or nurses who are faced with them, and who may not even have been involved in any of the issues/events leading to a complaint, and more support and training are needed. Participants nonetheless saw most complaints they had come across as justified and understandable. An important finding was also that service users are not clear about how a hospital works and that realistic information with regard to this could help manage expectations and improve service users' experience.

Theories of transformative learning (Mezirow, 1997) and minority influence (Moscovici et al., 1985) would suggest that if individuals or a minority change their views and behaviour consistently, this may induce change in others as well. In our study, the minority could be said to be the midwives who took part in the reflective discussion groups. They appeared aware of the role of communication in informal complaints management prior to the discussions, but the chance to discuss experiences with colleagues during the meetings deepened this understanding, and led to the insight that advanced communication training would be helpful for them. This process began when participants filled in a questionnaire relating to how confident they felt about communicating with service users, which was distributed during the first meeting. One midwife conveys how the questionnaire had made her more aware of the issues involved in communication:

'About the nonverbal cues and the verbal cues... it was really interesting to think about that because I wouldn't necessarily think about it because you automatically do it, essentially, and think about the things that you might not do as much and... how you could sort of disarm complaints in different ways' (Midwife 1).

During their final group discussion, the participants discussed the benefits of having taken part in the meetings. One participant felt reassured by these discussions with colleagues that she was *'doing it well enough'* (Midwife 7), by which she appeared to mean that she felt that she was generally capable of managing complaints. She was also reassured by the fact that her colleagues were finding the same things difficult, for example, dealing with aggression – a recurrent theme during the midwifery discussions. She felt that skills for managing aggression were generally lacking in midwifery and further training was needed:

'The other thing that's been really good is finding the same things difficult, so it's not me, it's not something lacking in me... that I find an aggressive person difficult, that's something we all find difficult, which probably reflects that we don't have a lot of skills given to us doing that [previous] training, to deal with that sort of thing' (Midwife 7).

Another midwife had begun to reflect more on her own and others' approaches to complaints management and dealing with aggression as a result of the collegial support she had received within the group meetings. She felt that more collegial support on the wards would be beneficial in certain situations:

'I felt that it's made me perhaps look at how I would deal with things in, in more depth than I would before (...) it's sort of, sort of re-affirmed that fact that I think in some situations where you're dealing with [aggression], you don't get the support from colleagues that you might wish that you had and that's, maybe that's come to light a bit, when we've been looking at this' (Midwife 8).

Following this deeper understanding of issues in communication, the action research group decided, in liaison with the participating midwives, that an advanced communication session using role play would be offered to them within the framework of the project. The half-day training with the midwives subsequently went ahead with two facilitators and a trained actor. A small group of midwives (n=3) played themselves, using real situations they had found difficult in the past, while the actor took on the role of service user. The aim was to have a group of six participants but due to busy delivery and maternity wards on the day of the training, it went ahead with three participants. The small number of participants, however, allowed plenty of time for each one to work through their issues in a safe and confidential environment facilitated by the researchers, both well versed in working with groups, the experienced actor, and supported by their colleagues. The first author was one of the facilitators. Each participant, in an iterative manner, worked through their chosen scenario at least twice, using feedback from the researchers, the actor and colleagues. All three participants had insights, perhaps best described as 'light bulb moments', when they realised that they were, in fact, capable of managing a complaints situation with service users effectively and that they could use the insights from the training day for a variety of situations.

Midwives attending the first training session evaluated the training on the day of the session and also approximately a month after the event. The participants were asked anonymously about the most important skill they would take away from the session and these are verbatim examples from the evaluation sheets from the training day:

'Tools to deal with future issues when communicating.'

'Empathy. The power of verbalising that you are sorry.'

'Feeling empowered to set the boundaries of the relationship between myself and the patient and her relatives.'

The follow-up, which took place via email, shows that participants had changed their practice in different ways following the training session exemplified below.

'There are a couple of things that I have noticed I have changed in my practice. The first one is that I no longer assume that patients or even colleagues understand what I say in the way I mean to say it. I am constantly checking for clues [i.e. nonverbal communication] to ensure that they understand exactly what I need them to. The second one is related to my [increased] ability to show empathy, particularly to patients when their expectations are not met.'

'Following the training I have really taken the time to think about how I communicate with patients and have become aware of how many closed questions I ask. I have tried to ask more open-ended questions, and have been trying to consider how I communicate with patients, including nonverbal communication. The training definitely helped me communicate with people who don't speak English very well. I think I have become a little more confident, and found the session very useful to stop and think about what and how I say.'

The reflective discussion groups and the training session were considered very useful by midwives as they deepened their understanding of communication and complaints management, and provided a useful tool for staff through 'learning by doing'. As stated above, although midwives seemed aware of the role of communication in informal complaints management prior to the discussion groups, the chance to discuss experiences with colleagues and the subsequent participation in the advanced communication training was beneficial. A randomised controlled trial evaluating the effectiveness of communication training on nurses also showed that it increased nurses' communication skills and level of confidence (Wilkinson et al., 2008).

Following the training in advanced communication skills, the participating midwives from the trust sought and received support from a supervisor to offer more training sessions to colleagues. The

researchers and the actor were subsequently invited to facilitate further training sessions with midwives, this time sponsored by the Royal College of Midwives, and one more session went ahead after the completion of the project. This illustrates that 'buy in' from a minority can be a catalyst for wider change.

Discussion

Using an action research approach, we have explored issues involved in informal complaints management by nurses and midwives. This has resulted in findings from collected data and reflections in relation to change in participants.

Responding to service user complaints is traditionally seen as worrying and problematic by healthcare staff (Lloyd-Bostock and Mulcahy, 1994; Allsop and Mulcahy, 1995; Cooke, 2006) and one should 'not underestimate the impact [on staff] of receiving a complaint for the first time' (Bennet and MacDougall, 2007, p 23). It can also be a complex endeavour because complaints are often informed by emotion and previous experiences, and we concur with the report from the House of Commons Public Administration Select committee that often 'complaints handling is more about understanding and empathy than process and outcome' (2014, p 5) – although complaints may also relate to practical concerns that should be straightforward for staff to address.

Although most service user complaints were seen as justified and understandable by participating staff, our data also show that staff need support and training to be able to manage complex informal complaints effectively, and they need to understand what is expected of them from their trust in this respect. Opportunities to reflect with colleagues about experiences were considered valuable by our participants and tailored communication training, such as that provided to midwifery participants, increased confidence in relation to complaints management. The Parliamentary and Health Service Ombudsman has also highlighted the need for staff training in its recent report on complaints handling in the NHS (Parliamentary and Health Service Ombudsman, 2013a).

Manley and colleagues discuss what fosters 'an effective workplace culture' that can contribute to a positive experience for patients, carers and staff alike, and they identify leadership as essential in this context. We argue that a positive change in a small number of staff, such as that seen in our participants, supported by their supervisor, has the potential to contribute to and improve 'the immediate culture' experienced by those at the healthcare frontline (Manley et al., 2011, p 1). In other words, a minority can act as catalyst for change. It is even possible that such a 'drip drip' approach to change and knowledge transfer is one that is most likely to persist and succeed in healthcare systems that consisting of a matrix of complicating circumstances, such as the NHS.

It was also clear from our qualitative data that service users generally do not understand how a hospital works, which contributes to the likelihood of complaints, and existing complaints systems are difficult to understand or negotiate for service users and staff. The Parliamentary and Health Service Ombudsman recently carried out a review of the NHS complaints system, resulting in three reports (Parliamentary and Health Service Ombudsman, 2013a, b, c), which fed into the Clwyd and Hart review (Clwyd and Hart, 2013), drawing attention to the fragmented nature of NHS complaints processes.

As previously stated, it is commonly assumed that complaints bring service changes, which is reflected in the wider literature, (for example, Cowan and Anthony, 2008; Hsieh, 2010; Jonsson and Ovretveit, 2008; Parliamentary and Health Service Ombudsman, 2013b). Some of our participants, however, noted that it can be counterproductive to base service improvements/changes on the views of a very small number of service users. Cooke also argues that 'complaints act as a distorting mirror magnifying problems in some areas while obscuring problems in others', suggesting that complaints are not a reliable tool for service improvement (Cooke, 2006, p 983). It has also been noted in a report on complaints mechanisms that complaints are not logged on databases in a consistent manner

in the UK, and that this may reduce the usefulness of complaints data (Health Professions Council, 2008). This echoes our findings from the complaints databases of the participating NHS trusts and findings of Jonsson and Ovretveit (2008), who suggest that complaints data can be valuable for service improvement, but recommend that the way such data are collected and logged be improved and streamlined to better inform development of services (cf. Siyambalapitiya et al., 2007).

Concluding remarks and implications for practice

Since the start of our project in 2011, the NHS has undergone organisational change under the Health and Social Care Act 2012. Another important event during this period has been the Francis Inquiry (Francis, 2010) following the significant care failings at the Mid Staffordshire NHS Foundation Trust outlined in the Francis reports (Francis, 2010; 2013). Other reviews and reports have subsequently sprung from the Francis reports. Professor Sir Bruce Keogh explored the quality of care in NHS trusts with consistently high mortality rates (Keogh, 2013), and Camilla Cavendish looked at training of healthcare assistants which promotes compassionate care (Cavendish, 2013). A review highly relevant to our project is that commissioned from Ann Clwyd and Tricia Hart by the UK government in response to the Francis reports in relation to complaints management (Clwyd and Hart, 2013). The Francis reports and those in their wake have highlighted an urgent need for reform of complaints management processes, which are viewed as ineffective, fragmented and difficult to negotiate for service users. However, the recent changes to the structure of the NHS may have caused complaints processes to become even more fragmented and unclear, rather than less so (see NHS Choices, 2013).

This paper has also been written against a backdrop of an ongoing intense media debate in the UK around the increasing pressures on the NHS and its future.

Our work thus constitutes a particularly timely contribution to the current debate and offers some new insights into healthcare complaints, as well as into the challenges of conducting action research in a complex health service under considerable pressure, and the fostering of learning and change against this backdrop. The action research approach helped to ground the work in the day-to-day busy reality of an NHS trust over a three-year period, where mutual trust was created with key collaborators and key stakeholders facilitating the collection and analysis of detailed and informative data. This busy context is less than ideal for conducting research but, at the same time, it is important to continue research on practice development in the NHS and action research provides a useful tool for doing so.

We recommend that the complexities involved in managing informal complaints at ward level for staff are acknowledged and that informal complaints management should be service user-focused, involving listening, engaging and responding. Realistic information for service users or 'signposting' about how a hospital works could help manage expectations and improve service user experience. Service users should also be put at the centre of formal complaints management, with transparent and clear processes put in place. Further, staff should be given regular opportunities to train and to receive support in order to develop their complaints management skills. Changes among staff working closely together should be fostered as this may contribute to a positive workplace culture, benefitting both service users and staff relative to informal complaints management.

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Anki Odelius (PhD, BSc, AHEA, RN, MN), Visiting Researcher, Faculty of Health and Medical Sciences, School of Health Sciences, University of Surrey, Guildford, UK.

Helen Allan (PhD, PGDE, BSc Hons, RNT, RN), Professor of Nursing, Adult , Child and Midwifery, School of Health and Education, Middlesex University, London, UK.

Billie Hunter (PhD, PGDip Midwifery, BNurs, PGCE, HV, RM, RN), Professor of Midwifery, Cardiff School of Nursing and Midwifery Studies, Cardiff University, Cardiff, UK.

Karen Bryan (PhD, BSc Hons, Cert RCSLT), Professor, Pro Vice-Chancellor and Dean of the Faculty of Health and Wellbeing, Sheffield Hallam University, Sheffield, UK.

Wendy Knibb (PhD, PGCE A, BSc Hons), Consultant Health Economist, Guildford, UK.

Jill Shawe (PhD, MSc, PCCEA, RN, RM, RHV, RNT, NP), Professor, Lead for Maternal and Family Health, Faculty of Health and Medical Sciences, School of Health Sciences, University of Surrey, Guildford, UK.