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ABSTRACT

Background: The number of complaints concerning aspects of care from patients and/or carers have increased over time. Yet, in spite of a growing body of national and international literature on health care 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 (AR) 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 AR 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 both staff and servicer users to negotiate. The AR approach facilitated learning and change in participants in relation to views on complaints management, and the main issues around 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 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

- The complaints systems need to be clearer for the benefit of service users and staff

- Staff need training and support which 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

Key words: action research, transformative learning, social change, health care complaints, patient complaints

INTRODUCTION

We have previously published a paper on critical reflection on practice development in this journal relative to an earlier stage of the RESPONSE project (Responding Effectively to Service users' and Practitioner's' 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 National Health Service (NHS) trust in the United Kingdom (UK) using AR (Odelius et al., 2012). The paper debates the challenges involved in using AR 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, in this paper drawing on the qualitative data from the study, we discuss how the AR approach and findings have contributed to practice development. We will focus the discussion on change as a key concept in AR using our AR project conducted in a complex health care context, drawing on transformative learning theory and the concept of social change. Detailed findings from the RESPONSE project are discussed elsewhere (Allan et al., 2015 -a; Allan et al., 2015 -b).

The RESPONSE project was based on identified priorities around the provision of quality services delivered by nursing and midwifery staff focussing 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 concerning poor communication and attitude involving health care staff (Sidgewick, 2006; The Information Centre for Health and Social Care, 2011, 2012, 2013, 2014). Front line staff such as nurses and midwives are often the first to be approached by patients or carers about concerns about care, or informal complaints (Parliamentary and Health Service Ombudsman, 2010); nonetheless little is known about how nurses and midwives manage complaints at ward level in spite of a growing body of research

on health care complaints (e. g. Anderson, Allan, & Finucane, 2001; Clwyd & Hart, 2013; Hsieh, 2010; Hsieh, 2012; Montini, Noble, & Stelfox, 2008; Tingle, 2014; Treanor, 2014). The Health Professions Council report that literature related to complaints in health care from a UK perspective can be divided into three main themes i.e. service user dissatisfaction, litigation and complaints processes; the latter forming the biggest part of the body of literature (2008). This is largely consistent with the literature review conducted to contextualise the present project, however our literature search also show that there are often largely unsupported connections made between complaints and improved health care in the literature which is discussed later.

An AR approach (see later) with mixed methods provided a useful springboard to, together with colleagues and collaborators, explore issues surrounding informal complaints management by nurses and midwives. Particularly the qualitative methods which we are presenting in this paper facilitated an in depth exploration of this previously under researched area.

We begin by giving an overview of the ideas underpinning AR, transformative learning and social change and discuss these in relation to our project. We then define our methods, findings and AR process before the discussion, concluding remarks and outlining of implications for practice.

ACTION RESEARCH, TRANSFORMATIVE LEARNING AND SOCIAL CHANGE

AR 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.

AR methodology, also described in the previous article (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). AR 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 in nursing (Holter & Schwartz-Barcott, 1993). AR 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 AR and that change is anticipated to place in different ways e. g. in relation to learning and empowerment. It is also clear that understanding and action are interlinked (see also Brown, 1989; Merton, 1968; Thomas & Thomas, 1928) .

As well as change, other pillars of AR are participation and equality (Bradbury Huang, 2010), or a democratic way of working through the AR process (Hilsen, 2006). AR is also expected to induce empowerment of the participants which is also evident in the above quote (Snoeren, Niessen, & Abma, 2011). The AR process is cyclic and relies on reflexivity; and traditionally involves interventions of some description although this is not strictly necessary (Waterman, Tillen, Dickson, & de Koning, 2001). To become credible 'action researchers' therefore requires 'multidimensionality' to be able to conduct effective AR (Bradbury Huang, 2010 p 108).

Increasingly, an affinity between AR 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 article (Odelius et al., 2012) has emerged in the past decades in adult learning to support the development of teaching in higher education, and has remained influential in this field extending to other fields as well (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 discuss in the above paper how transformative learning in our project took place on individual, NHS trust and research organisation levels; and also discuss the importance of support from senior trust management level for implementation and sustained change to occur throughout the trust.

However, problems with health care complaints management are not just confined to the NHS trust we collaborated with, but apply to health care systems nationally and globally (e. g. Anderson et al., 2001; Clwyd & Hart, 2013; Hsieh, 2010; Hsieh, 2012; Montini et al., 2008; Tingle, 2014; Treanor, 2014) and therefore research in this area is likely to be of interest to the wider research community. Nevertheless, since AR and transformative learning promotes change through individual learning and learning in groups and organisations of limited sizes, 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 which are not easily translated. In fact, Mezirow's ideas have been critiqued for not sufficiently taking into consideration the context and its role in transformative learning (Levine & Scott Tindale, 2015).

'Social change' is frequently claimed to be the ultimate aim for conducting AR 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 in AR research. Coulter also argues that the value of using AR 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 AR and the often complex issues researchers use AR to explore (Waterman et al., 2001), it is perhaps not possible to be entirely clear about aims prior to commencing the research process; particularly given that the focus of a project can often shift during the process

of conducting the research, which is also one of the particular strengths of AR which can lead to unexpected and useful findings (see also Bridges & Meyer, 2007 on this). If issues of potential interest to a wider audience are researched, however, it could be beneficial for AR researchers to reflect on the anticipated scope of change given its centrality in AR.

Social change, although frequently referred to as an aim in AR, implies a wider impact than that which is normally associated with AR, which encompasses individual/local learning and change in particular environments. Although it is expected that findings from locally based AR projects are also disseminated more widely (Meyer, 2000), this is not the same as wider social change. That is, discussions rarely move beyond the immediate context of the AR 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 also argues that AR 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 in AR, asserts that there can also be a tension between a desire to keep up a well working local partnership with a desire to generalise findings (Bradbury Huang, 2010). In other words, a wish by a research team 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 to bottom approach to change and the latter means a bottom up approach to change. Nevertheless it is possible that both could affect the AR process and the findings. Therefore social change, in its wider meaning, is a challenging concept in relation to a locally based AR project such as ours with a limited number of participants; although it could be expected that findings from an AR project 'can be relevant elsewhere' (Williamson, Bellman, & Webster, 2012 p 39). We did not reflect on the

scope of the possible learning and change prior 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. In order 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 that of Moscovici's minority influence concept (1985) which we are going to use as a framework for the discussion in this paper. The reason for this choice is that the change we are discussing in in this context is the change experienced by a limited number of individuals in one NHS trust (see below), that is a minority, and 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 (Levine & Scott Tindale, 2015; Moscovici & Lage, 1976; Moscovici et al., 1985). Moscovici challenged the then prevailing idea in this area of research that majority influence i. e. the minority conforming to the majority, was to be taken for granted; and instead posited that one or more individuals, i. e. a minority can successfully influence a majority subject to certain conditions (Levine & Scott Tindale, 2015). Consistency is one of those conditions important in minority influence if it is to lead to social change (Moscovici et al., 1985). Moscovici's ideas were developed and critiqued for many years (Levine & Scott Tindale, 2015). One of the most influential developments of Moscovici's theory holds that the perceived status of those who attempt to influence others plays an important role regardless of whether they belong to a majority or minority (Tajfel, 1979; Turner, 1991).

Moscovici (1985) proposes that traditionally influence is 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. He also states 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 health care related complaints, perceived decreased patient satisfaction and the challenges staff experience in relation to this. Consensus would mean that the majority i. e. most health care staff across the board, 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 AR 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 i. e. a profound 'buy in' from the minority, and the learning internalised in order for it to be able 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). Health care systems are complicated and politicised and therefore subject to recurrent changes in policy which affects nursing and how nursing can be carried out by nurses (Traynor, 2013). This was also evident in our data and that, coupled with the current [financial] pressure the NHS is under might also, realistically, limit the scope of change possible.

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 if the change will indeed extend to trust level.

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

Issues in generalisation and transfer of knowledge and change in AR are shared generally with qualitative research which is an area that has traditionally grappled with this. Further, 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 researchers debate whether or not culturally specific knowledge or values are even possible to transfer across cultural boundaries (Littlewood, 1998; Opala & Boillot, 1996).

METHODS, FINDINGS AND THE ACTION RESEARCH PROCESS

As previously stated the RESPONSE project was initiated against the back drop 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; Hsieh, 2010; The Information Centre for Health and Social Care, 2014; Wong, Ooi, & Goh, 2007). The initial focus on communication shifted slightly in response to findings during the first phases and cycles which is detailed later.

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

AR is not a linear approach to research and there are a variety of orientations in AR detailed in the literature; and 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' where changes normally do not extend beyond those who directly participate in the research (Holter & 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 article as taking place on both organisational and individual levels (Odelius et al., 2012).

We will discuss our AR approach beginning by outlining methods and findings drawing from the qualitative data, and then detail the AR process depicted in the diagram below (first published in Allan et al., 2015 -b) (participation was discussed as an important cornerstone in AR in the previous article). We will then focus the discussion on change using feedback from advanced communication training with midwives which was run during one AR cycle (see Allan et al., 2015 -b 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 – 2014. Overall, collected data for this mixed methods project included NHS complaints data from trust data bases, 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 01/01/2011 – 31/06/2011 were collected from three NHS trust data bases as well as from a midwifery 'debriefing service' in the main trust, and these data were subsequently subjected to content analysis to categorise the data (Graneheim & 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 being analysed 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 ARG. Three main themes were agreed on which relate to the complex context of complaints and complaints management, 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 AR 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 ARG 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 which led to insights about what was functioning well and less well relative to complaints management in their trust. This is evidenced in minutes from ARG 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 & Frost, 2011 p 4). The ARG 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. The latter trust also provided anonymised data from a separate data base 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 ARG prior to phase three which used three action research cycles involving, firstly, reflective discussion groups with midwives. Eight one hour long audio recorded discussion groups were conducted over nine months facilitated by the first author of this paper (n=6). 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 ARG 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 ARG 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 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 ARG members who were key stakeholders from the trust although conducted and analysed by the research team. These trust 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 ARG.

This is consistent with AR which can 'be unpredictable' and it is often not possible to foresee how an AR project will evolve (Bridges & Meyer, 2007 p 391). The difficulty in envisaging how an AR project will evolve can also complicate the ethical approval process which is largely due to researchers and ethics committees having competing views on what research means; but ethics committees are becoming increasingly familiar with the AR paradigm which should make the process easier in the future (Gelling & 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.

Insert diagram 1

The role of communication in complaints and complaints management, an initial focus, remained an important theme as we had initially anticipated but through reflection was considered a part of the generally complicated background alongside single complaints consisting of multiple issues relating to different members of staff; often played out against a highly 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 causing 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 to be able to discuss experiences with colleagues during the meetings further deepened this understanding, and lead 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 because 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 what you, how you could sort of disarm complaints in different ways. (mw 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'"* (mw 7) by which she appeared to mean that she felt that she was generally capable of managing complaints, and also by the fact that her colleagues were finding the same things difficult e. g. dealing with aggression which was 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 needs, that I find an aggressive person difficult or it's, 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. (mw 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, and 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. (mw 8)

Following this deeper understanding of issues in communication the ARG 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 and 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 participant 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 from, 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 it further 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, to be able to discuss experiences with colleagues during the discussion groups and the subsequent participation in the advanced communication training further deepened their understanding and insight. A randomised controlled trial evaluating the effectiveness of communication training on nurses also show that nurses' communication skills and level of confidence had increased following their training (Wilkinson, Perry, & Blanchard, 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; and the researchers and the actor were subsequently invited to facilitate further training sessions with midwives, this time sponsored by the Royal College of Midwives (RCM), and one more session went ahead after the completion of the project. This shows that 'buy in' from a minority can be a catalyst for a wider change.

DISCUSSION

Using an AR approach we have explored issues involved in informal complaints management by nurses and midwives which have resulted in findings from collected data and reflections in relation to change in participants.

To respond to service user complaints is traditionally seen as worrying and problematic by health care staff (Allsop & Mulcahy, 1995; Cooke, 2006; Lloyd-Bostock & Mulcahy, 1994) and one should "not underestimate the impact [on staff] of receiving a complaint for the first time" (Bennet & MacDougall, 2007: 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 Public Administration Select committee (PASC) 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 effectively manage [complex] informal complaints, and they need to understand what is expected of them from their trust in relation to complaints management. Opportunities to reflect with colleagues about experiences was considered valuable by our participants and tailored communication training such as that provided to midwifery participants increased their confidence in relation to complaints management. The Parliamentary and Health Service Ombudsman has also highlighted the need for staff training in their recent report on complaints handling in the NHS (2013a).

Manley and colleagues discuss what fosters 'an effective work place culture' which 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 of our participants, supported by their supervisor, has the potential to contribute to and improve 'the immediate culture' that is the work place culture at the health care front line (2011 p 1). In other words a minority can act as catalyst for change. It is even possible that this 'drip drip' approach to change and knowledge transfer is one that is most likely to persevere and succeed in health care systems 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 service user dissatisfaction and complaints, and existing complaints systems are difficult to understand or negotiate for both 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 & Hart, 2013), drawing attention to the fragmented nature of NHS complaints processes which service users find perplexing.

As previously stated, it is commonly assumed that there is a link between complaints and improved services which is reflected in the wider literature, (e. g. Cowan & Anthony, 2008; Hsieh, 2010; Jonsson & 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 one or 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' thus indicating that complaints are not a reliable tool for service improvement (Cooke, 2006: 983). It has also been noted in a report on complaints mechanisms that complaints are not logged on data bases in a consistent manner in the UK and that this may reduce the usefulness of complaints data (Health Professions Council, 2008). This also echoes our findings from the complaints data bases of the participating NHS trusts and findings from Jonsson and Ovretveit (2008) who suggest that complaints data can be valuable for service improvement, but recommend that the way complaints data are collected and logged is improved and streamlined to better inform development of services (see also Siyambalapitiya et al., 2007).

CONCLUDING REMARKS AND IMPLICATIONS FOR PRACTICE

Since the start of our project in 2011 the NHS has undergone organisational change following the Health and Social Care Act 2012 (Health and Social Care Act, 2012). Another important event during this period has been the Francis Inquiry (Francis, 2010) and the significant care failings at the Mid Staffordshire Foundation Trust outlined in the Francis reports (Francis, 2010, 2013). Other reviews and reports have subsequently sprung from the Francis reports (Francis, 2010, 2013). Professor Sir Bruce Keogh (Keogh, 2013) explored the quality of care in NHS trusts with consistently high mortality rates, and Camilla Cavendish looked at training of health care assistants which promote compassionate care (Cavendish, 2013). A review highly relevant to our project is that commissioned from Ann Clwyd and Tricia Hart by the Government in response to the Francis reports in relation to complaints management (Clwyd & 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 possibly leading to the serious failures. However, the recent changes to the structure of the NHS (Health and Social Care Act, 2012) may have caused complaints processes to become even more fragmented and unclear rather than less so (see NHS Choices, 2013).

This paper is also 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 health care 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 back drop. The AR approach facilitated a grounding in the day to day busy reality of an NHS trust over three years 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 very important to continue research on practice development in the NHS and AR provides a useful conduit 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 focussed involving listening, engaging and responding. Realistic information for service users or 'sign posting' about how a hospital works could manage expectations and improve service user experience. Service users should also be put at the centre of formal complaints management with transparent and clear complaints processes put in place. Further, staff should be given regular possibilities to train and to receive support in order to develop their complaints management skills. Changes among staff working in close work teams should be fostered as this may contribute to a positive

work place culture benefitting both service users and staff relative to informal complaints management.

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