Organisational strategies and practices to improve care using patient experience data in acute NHS hospital trusts: an ethnographic study

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Scientific summary

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Background

Patients' and carers' experiences of hospital care are an important aspect of health-care quality. In the NHS, data about patients' experiences are collected through a wide range of methods, including detailed postal questionnaires (e.g. the national Adult Inpatient Survey), much smaller sets of satisfaction-type questions [including the nationally required 'Friends and Family Test' (FFT)], formal and informal complaints and compliments, patient stories, and feedback posted on patient/public websites (such as NHS Choices and Care Opinion). Such data are collected so that they may then be used to fulfil a wide range of functions. These include identifying local quality improvement (QI) priorities, allowing organisations to benchmark their performance against their peers, publicising the results to the general public as part of wider engagement and transparency efforts, and informing internal and external quality inspections and regulatory processes. Despite the abundance of patient experience data in the NHS, there is limited understanding of how these data inform QI specifically, and the changes to services that are made as a result.

Objectives

This study had two related aims. The main aim was to explore and enhance the organisational strategies and practices through which patient experience data are collected, interpreted and translated into quality improvements in acute NHS hospital trusts in England. The secondary aim was to understand and optimise the involvement and responsibilities of nurses in senior managerial and front-line roles with respect to such data.

Methods

Our study was organised into two overlapping phases. Phase 1 (February 2016–January 2018) consisted of a 12-month ethnographic study of five acute NHS hospital trusts in England informed by actor–network theory (ANT). Phase 2 (January–May 2018) included a series of sense-making workshops modelled on Joint Interpretive Forums (JIFs), which brought together different stakeholders to distil generalisable principles for optimising the use of patient experience data in NHS organisations. The first of these JIFs was attended by representatives from all five participating trusts, as well as policy-makers; five other JIFs were held at each of the trusts between February and May 2018 and were attended by a range of trust staff. The invitations to trusts to participate in the research were guided by a sampling strategy based on trust performance in the 'overall views and experiences' section of the Care Quality Commission's Adult Inpatient Survey and preliminary findings from a national survey undertaken as part of another National Institute for Health Research (NIHR) study; it also took into account additional factors such as location, size, willingness to participate and research burden. At each trust, we focused our ethnographic observations on two areas of clinical care (cancer and dementia) so that we could explore areas offering sufficient similarities and differences for fruitful comparison. The majority of our data consisted of detailed field notes from our ethnographic observations and informal conversations during 116.5 days of fieldwork, transcripts from 65 interviews with key informants and copies of relevant trust documents (e.g. board papers and committee agendas and minutes); these were supplemented by photographs we took to capture significant aspects of patient experience data collection and processing. Collection and analysis of our research data were guided by ANT tools and sensibilities. This means that we focused on how patient experience data travelled in each organisation and on the associations and interactions between these data and other human and non-human actors. Data analysis proceeded through both individual researchers' study of, and reflection on, ethnographic data, and regular discussion in groups of different sizes (field researchers alone

as well as the whole research team). Data from the JIFs, in the form of notes from the events, were analysed through discussion in small team meetings. This study was funded by the NIHR Health Services and Delivery Research programme. It was approved by the London Bridge Research Ethics Committee [Integrated Research Application System (IRAS) identification number 188882] and Health Research Authority. It is registered on the NIHR CRN portfolio with reference number 188882.

Findings

Our findings are organised around five inter-related themes.

The multiple form of patient experience data

Each type of patient experience data (e.g. the FFT, the Adult Inpatient Survey and patient stories) takes multiple forms as it undergoes a number of transformations while travelling through a hospital. Some of these transformations involve relatively well-rehearsed and regular steps, whereas others show less consistency of process. We have found that the different 'versions' of any one type of data emerging from these transformations can lead to care improvements in different ways. For example, different 'versions' of the FFT, including a single feedback card with open-text comments, a trust's regular internal report of FFT results and a dashboard appearing in a board report, may all have effects in different ways and at different levels of the organisation. A comment on a FFT card might be reviewed and acted on almost in real time (a matter of days) by ward staff. A regular internal report may be the form of the FFT that a matron interacts most with and that may prompt changes in his or her service. A dashboard in the papers for an executive board meeting may reassure managers that, overall, patients are commenting positively on their experiences at the trust. The analysis suggests that the multiple nature of *each* type of patient experience data cannot be overlooked if we aim to understand in-depth how improvement is enabled.

Specific qualities contribute to linking data to quality improvements

When we observed that quality improvements take place in response to patient experience data, this was typically when data participated in interactions, with humans and/or non-humans, that were characterised by the qualities of autonomy (to act/trigger action), authority (to ensure that action is seen as legitimate) and contextualisation (to act meaningfully in a given situation). We found that these qualities were not inherent properties of actors but emerged in interactions. For example, we saw that clinical nurse specialists (CNSs) in the context of cancer care, by virtue of this role's formal responsibility for patient experience, were able to act on the data in ways that clearly led to improvements in care. Organisationally recognised and validated mechanisms such as ward-accreditation schemes based on the integration of experience, safety and clinical outcome data were examples of non-human actors interacting with patient experience data and bringing about the qualities we have discussed. Another example was represented by external entities such as a Clinical Commissioning Group (CCG) requesting formal reporting on the impact of patient experience data on improving local services.

The responsibility for patient experience data work largely lies with nursing staff, but other professionals have important roles

Nurses largely have ultimate responsibility for how data are collected, interpreted and used to improve care, but other professionals also have important roles. We observed how the organisation of patient experience data work varied across the five participating trusts and the remarkable extent to which patient experience teams (where such formally designated teams existed) differed. Two of the trusts in our sample did not have formally designated patient experience teams. In one other trust, the patient experience team and the patient advice and liaison team operated separately, whereas at two other trusts these remits were blended. Clerical staff (helped by volunteers) are often involved in the generation and processing of patient experience data but tend to have a very limited role in linking the data to action for improvement. Participants in the cross-site JIF held in phase 2 of the study showed significant interest in the way different trusts organised their patient experience data work and in the composition and remit of patient experience teams.

Formalised quality improvement work is often very removed from 'everyday quality improvement'

There is often a disconnect between the quality improvement work we refer to as formal QI (i.e. the strategic projects and priorities the organisation recognises under this label) and what we call everyday QI (i.e. the multitude of actions and interactions that bring about change and improvement but are not formally reported or acknowledged as QI). Formal QI teams and responsibilities are often quite removed from patient experience data work, with patient experience teams having limited contact with QI teams and vice-versa. Formal QI can confer authority to patient experience data work (as we saw in the case of structured 'learning sessions' modelled on QI principles and tools such as 'plan, do, study, act' cycles at one of the study sites). However, patient experience data more commonly lead to action for improvement in ways that are not formally identified as QI work, such as in the case of changes in care resulting from CNSs' taking the initiative to address areas of experience not covered by national surveys.

Sense-making exercises with study participants can support organisational learning

Staff at the participating NHS trusts were very keen to take part in our study, especially in the multistakeholder workshops (JIFs) during phase 2 of the research. They were interested in sharing their challenges and successes relating to patient experience data work with colleagues from other trusts and eager to identify potential learning opportunities. Trust-based workshops highlighted how participants could take ownership of these events and contribute to identifying the practical relevance of our emerging analytical considerations and findings to their local contexts. As a result of the discussions held at the JIFs, trusts could reflect on key areas of work for local improvement. At one trust, for example, it was recognised that more work could be carried out to improve communication between managers and front-line staff with regard to awareness of changes taking place in response to patient experience data; at another trust, it was resolved that it would be useful to organise a Nurses Day, when staff who had worked to improve patient experience could be acknowledged by the trust and their colleagues.

Conclusions

Our findings have the following implications for policy and practice:

- Our data suggest that, for patient experience data to lead to improvements in quality of care, it is not sufficient to focus solely on improving, and/or maximising the number of, the data that NHS trusts collect. This effort yields limited benefits if attention is not also paid to the qualities (in particular autonomy, authority and contextualisation) that are needed to characterise the interactions between the data and other (human and non-human) actors for the data to lead to care improvements.
- QI research and practice would benefit from approaches that take into account the emergent, often real-time, nature of much improvement work and, more specifically, of the complex relationships between institutionally recognised QI efforts (formal QI) and the vast amount of unsystematised improvement work that takes place in response to patient experience data in less well-documented ways (everyday QI).
- There is a frequent disconnect between the data-generation and transformation work carried out by front-line nursing staff and patient experience teams (or clerical staff with patient experience responsibilities where formally designated teams do not exist) and actions for care improvement resulting from these data, which are more often the responsibility of nursing leadership (including deputy and divisional directors of nursing, matrons, CNSs). Where such disconnects exist, there are missed opportunities for more effective distribution of the qualities that support everyday improvement work. Acute NHS hospital trusts may be able to optimise the use of patient experience data by exploring configurations of, and possible collaborations between, different professionals and teams involved at different stages of patient experience data work.

- Organisational tools and mechanisms that give authority, autonomy and contextualisation to patient experience data may make external drivers, such as national targets or the mandatory nature of data generation, less critical than they would be in the absence of such mechanisms. Accordingly, organisations that can successfully establish mechanisms that embed action as a result of patient experience data work may find external drivers less important and potentially burdensome.
- Finally, multistakeholder workshops in the form of JIFs provide valuable opportunities for organisational learning in the exchange of experiences within and between organisations. For example, some of the models orienting service response to data in the context of cancer care may prove, with due adjustments, viable and promising in the patient experience data work aimed at improving care for people with dementia.

Recommendations for research

- Further research examining the ways in which data on patient safety, patient experience and clinical outcomes intersect and interact in the everyday practices of hospital work (e.g. care on the wards, meetings, reports) and inform particular forms of improvement work would provide useful insights into how to inform developments in improvement science.
- Organisations external to NHS trusts, such as CCGs, large charities (e.g. Macmillan Cancer Support) and contractors (e.g. Quality Health and Picker), play an important role in the organisation of the micropractices of patient experience data work. Further research should consider exploring in more detail the ways in which these organisations enable or constrain patient experience data work and QI, especially the everyday QI described here.
- The highly participative and practically relevant sense-making afforded by multistakeholder workshops supports an engaging framework for applied health-care research. These workshops strengthen research collaborations between academia and health-care providers and contribute to participants' ownership of at least part of the research process. Further research into the long-term impact of contributing to, and participating in, such workshops on individuals and organisations is desirable.

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