Using patient experience data to develop a patient experience toolkit to improve hospital care: a mixed-methods study

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Scientific summary

Developing a patient experience toolkit to improve hospital care

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Scientific summary

Background

There is now near universal agreement that receiving feedback from patients about their experience of care is necessary in order for high-quality care to be delivered. Evidence has demonstrated that patient experience (PE) is positively associated with clinical effectiveness and patient safety. Within the NHS, a significant level of resource is now allocated to the collection of patient feedback through the Friends and Family Test (FFT). Other measures include national and local surveys, complaints, safety incidents and comments on social media. However, the overt emphasis and huge resource allocated to collecting PE feedback has not been matched by efforts to use these data to make improvements to future care delivery. Although there appears to be widespread enthusiasm to make changes to improve PE, several potential barriers exist that can inhibit health-care staff from acting on these data. These relate to health-care staff lacking expertise in quality improvement (QI), not being confident in interpreting feedback effectively, and a lack of autonomy and resource to deal with problems that are outside their immediate sphere of control. Systemic, proactive changes are often minimal, with a focus instead on ‘quick fixes’.

This programme of work aimed to understand the key issues facing health-care staff in their varying ability to use PE feedback and then to develop and test a Patient Experience Toolkit (PET) to enable improvements to be made.

Objectives

The overall aim of this project was to understand and enhance how hospital staff learn from and act on PE data. The following objectives allowed us to achieve this aim:

1. Understand what PE measures are currently collected, collated and used to inform service improvement and care delivery.
2. Co-design and implement a PET using an action research (AR) methodology.
3. Conduct a process evaluation to identify transferable learning about how wards use the PET and the factors that influence this.
4. Refine and disseminate the PET.

Methods

The programme of work was predominantly qualitative, with four interlinking work packages closely aligned to our objectives, which incrementally built on each other. The programme ran from November 2015 to June 2018 and during this time we worked closely with six ward-based clinical teams, across three NHS trusts in the north of England (two at each trust). Integral to the study were eight patient representatives, who were actively involved in the research study, and numerous members of staff within PE teams at all sites. In this summary, we report on the first three work packages separately and discuss how the PET was refined in the sections where this is relevant.

Scoping review and qualitative exploratory study

These activities were conducted between November 2015 and August 2016.

The scoping review comprised hand-searching and a search of the academic and grey literature databases, websites and material identified through the researchers' own knowledge of the field. This was a scoping review rather than a systematic review to enable flexibility pertaining to grey literature. We focused on UK sources only. Once completed, we then developed a list of 12 key descriptive characteristics regarding the role of different patient feedback in relation to QI.

The qualitative exploratory study was conducted using focus groups with ward-based staff and individual interviews with middle and senior management in the trusts. In total, 50 participants took part. A high-level, conceptual analysis was performed to discern factors on both a macro and a micro level that hinder the use of PE feedback in service improvement.

The findings of the above two research activities were taken forward to inform the next work package.

Co-design of a Patient Experience Toolkit and testing using action research

The co-design process was undertaken between September 2016 and January 2017. The AR study was conducted between February 2017 and February 2018.

The main focal points for the co-design process were three half-day workshops, which brought together staff from the six ward teams, patient representatives and members of the research team. Workshop 1 used LEGO® (The LEGO Group, Billund, Denmark) Serious Play methodology [James A. *Innovative Pedagogies Series: Innovating in the Creative Arts with LEGO – Transforming Teaching; Inspiring Learning*. 2015. URL: www.heacademy.ac.uk/innovating-creative-arts-lego (accessed 13 July 2018)] to identify and problematise the key issues relating to patient experience feedback. Workshop 2 presented ideas and concepts (derived from the previous workshop) back to participants to help decide on a toolkit prototype. Workshop 3 asked delegates to work through an early prototype of the PET. The process of toolkit development was iterative across, between and beyond the three workshops.

The co-design process and the AR study were inextricably linked. Eight heuristic statements were developed from the co-design process to capture the theoretical premises of the PET and these were taken forward to be tested in the AR phase. In brief, they focused on a multidisciplinary approach, patient and public involvement, collecting current patient feedback, triangulation of different feedback, PE team involvement, facilitation of group reflection and planning, applying improvement methods and developing skills, and celebration. Ward staff and patient representatives were all viewed as co-researchers during this stage. Cycles of AR took place, based on a model of organisational change. Specific methods used to structure the AR study were the story dialogue technique and ongoing consultation exercises. A thematic analysis was undertaken regarding how the heuristic statements had changed over time.

Process evaluation

The process evaluation ran alongside the AR study, from February 2017 to February 2018.

This was a large, mixed-methods evaluation. The qualitative part of the evaluation was based on ethnographic observations by the evaluator of key meetings, in-depth interviews at the half-way and end point with key stakeholders and detailed reflective diaries kept by action researchers. Framework analysis was employed.

The quantitative part of the evaluation was based on a 12-item PE survey being completed by around 15 to 20 patients per week in total (across the six wards) for 14 months. Data collection began 4 weeks before the AR formally started and ended 4 weeks after it formally ceased. The same researchers collected the data from patients on a particular ward on the same day of the week. Data were analysed using statistical process control charts.

Findings

Scoping review and qualitative exploratory study

The scoping review found 38 different types of feedback across the academic and grey literature, which can be divided into four categories: hospital-initiated quantitative surveys, patient-initiated qualitative feedback, feedback and improvement frameworks, and other sources. Although there are many different types of PE feedback available to use within UK hospitals, there are few that can be easily used for the purpose of QI.

The findings of the qualitative study showed that the effective use of PE feedback is hindered at both the micro level (of how individual clinicians and teams of staff have difficulty engaging with the data sources) and the macro level (how organisational structures are unwittingly preventing progress). This is played out through various means in a macro sense, such as a lack of pan-organisational learning, the intense focus on the collection of data at the expense of understanding how they could be used and fractured PE teams who want to assist ward staff but find this difficult. In a micro sense, a large amount of generic positive feedback is seen as unhelpful, with ward staff struggling to interpret various formats of feedback while they question the value of it because of factors such as the timeliness and validity of the data. The macro and micro prohibiting factors come together in a perfect storm that provides a substantial impediment to improvements being made.

Co-design of a Patient Experience Toolkit and testing using action research

The findings of the co-design process were iterative between workshops, with the findings from the first workshop being taken forward into the second and then the findings from the second being used to structure the third. Development of the toolkit prototype occurred between workshops. Common areas of interest that arose from the first workshop were used to structure the content of the second workshop. Three themes emerged from the second workshop: forms of data and their uses, people and relationships, and environments. These themes were then worked into a set of core principles that were used to structure the prototype of the toolkit. The first prototype was then developed prior to workshop 3. The design team reflected on the process of the participants working through the first prototype (in the third workshop) in order to develop a PET for use during the AR testing phase. The PET was then periodically refined during the 12 months of testing in reaction to what the action researchers were finding on the ground.

The action researchers re-examined their eight heuristic statements that were proffered prior to the start of the AR phase. They found that their heuristic statements had shifted as a result of 12 months of testing the PET with ward staff. Rather than go through each of the eight statements in turn, we have chosen to focus in this summary on the most interesting aspects of what the action researchers found, which are detailed below.

The idea that current PE data can be effectively triangulated for the purpose of improvement is largely a fallacy. Rather, additional but more relational feedback had to be collected by patient representatives, an unanticipated element of the study, in order to provide health-care staff with data that they could work with more easily. Multidisciplinary involvement in PE initiatives is difficult to establish unless teams already work in this way. Regardless, there is merit in involving different levels of the nursing hierarchy. Consideration of patient feedback by health-care staff can be an emotive process that may be initially difficult and needs dedicated time and sensitive management.

Process evaluation

The qualitative part of the evaluation found that the six ward teams engaged variably with the AR process over a 12-month period, with some teams implementing ambitious solutions that were sustainable in the long term. Conversely, other teams focused on time-minimising ‘quick wins’. Facilitation of the toolkit was central to its implementation. That is, where ward staff were able to embed improvements, it was not necessarily related to the use of the physical toolkit itself but more about the motivation and encouragement of the action researchers. The most important factors here were the development of relationships between people and the facilitator's ability to navigate organisational complexity.

Within the quantitative aspect of the evaluation, 1028 surveys were completed by patients across the six wards. There was a small general decline in PE over the study period, although a secondary analysis appears to show an association between full implementation of the PET and improving PE.

Conclusions

Formalised sources of patient feedback (e.g. surveys or the FFT) are used for assurance and benchmarking purposes by hospital management. Ward staff often do not have the time or the analytic skills to be able to take these data and use them to identify PE issues in order to make improvements. These sources also often lack detail and do not provide staff timely insight into the needs and preferences of their patients. This means that the current manner in which PE feedback is collected and used is generally not fit for the purpose of enabling health-care staff to make meaningful local improvements.

The PET was co-designed with health-care staff and patient representatives but the mechanism for change is most likely to lie in the skilled facilitation provided by the action researchers. This primarily took the form of motivation, guidance, flexibility, encouragement and responsiveness. Moving forward, skilled facilitation of the toolkit will be required in order to achieve successful outcomes in different contexts.

The emotional nature of the process of health-care staff being asked to consider feedback from their own patients cannot be underestimated. Ward staff needed not only practical support to be able to consider feedback but also emotional support. Under workforce and resource constraints, some staff felt helpless to address their patients' concerns. The sensitivity of the facilitation style was paramount to encourage small steps to be taken and also encourage a celebration of success.

Despite these identified issues, the development and testing of the PET was an exciting programme of work that is likely to have important implications, moving forward. The data collected here demonstrate that, when staff become involved in a project of this kind, it enables change that can benefit the experience of their patients.

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