Keywords Patient experience/Quality improvement/Cross-team working

This article has been double-blind peer reviewed

In this article...

- The benefits and challenges of collecting and using patient experience feedback
- The six-step toolkit developed to help teams use feedback to improve care
- Results of the toolkit's testing period with frontline ward teams

Testing a toolkit that uses patient experience feedback to improve care

Key points

Patient feedback is vital to providing high-quality care but, despite being collected, it is often not used to improve care

The Bradford Institute for Health Research led a project to develop the Yorkshire Patient Experience Toolkit

The six-step toolkit was tested over the course of one year on six diverse wards, with facilitation support from academics

Testing showed collaboration is essential and teams require expert support, particularly when dealing with emotional feedback

A coaches' network is training staff to support frontline teams with using the toolkit

Authors Claire Marsh is senior research fellow, Bradford Institute for Health Research; Rosemary Peacock is research fellow, School of Medicine, University of Leeds; Laura Sheard is associate professor, York Trials Unit; Rebecca Lawton is professor, Bradford Institute for Health Research; at the time of the research, all were at Bradford Institute for Health Research.

Abstract Listening and responding to patients is essential but healthcare organisations struggle to do this effectively. This article describes a project to create the six-step Yorkshire Patient Experience Toolkit, which supports teams to collect and use patients' feedback to improve care. Six wards trialled the toolkit and found that, while it addressed complex patient needs, the teams needed skilled support and collaborative processes.

Citation Marsh C et al (2021) Testing a toolkit that uses patient experience feedback to improve care. *Nursing Times* [online]; 117: 1, 39-43.

Instilling a culture of listening is essential if the NHS is to provide safe, high-quality care (Francis, 2013); ensuring patients' and carers' concerns can be raised and responded to effectively is central to this process. It not only feels instinctively 'right'; there is also evidence that experience of care is linked to clinical outcomes and patient safety (Doyle et al, 2013).

Patients and their carers have unique perspectives that add detail and context to what clinicians may already know, and can spot specific problems that may otherwise be missed (O'Hara et al, 2018). Against this backdrop, NHS organisations are now mandated to collect large amounts of patient experience (PE) feedback, including national inpatient surveys and, in England, the Friends and Family Test (FFT). However, despite the large number of surveys undertaken, in the main their results are not used to inform improvements to care (Coulter et al, 2014).

The Bradford Institute for Health Research (BIHR) led a research and innovation project that had three parts:

- Part 1 – qualitative research, including a scoping review to understand the barriers to effective use of PE feedback in hospital settings;
- Part 2 – using the findings from part 1 to co-design and test solutions in the form of a patient experience toolkit (PET) with, and for, hospital staff;
- Part 3 – an independent evaluation of the toolkit's potential for wider spread.

This article first briefly summarises the barriers revealed in part 1 of the project but focuses on the PET that was developed in response to these. We discuss how it was co-produced with staff and patients in three acute hospitals in Yorkshire and Humber, tested and refined over the course of a year in six different hospital settings, then launched more widely as the Yorkshire Patient Experience Toolkit.

Understanding the barriers

Research findings from part 1 of the collaborative programme described the situation as a "perfect storm" – of intense PE feedback collection but with no organisational

systems to allow anyone to learn from, or respond to, that feedback (Sheard et al, 2019). This leaves cross-organisational teams (for example, PE staff) overrun with data management and frontline staff largely unable to access or understand meaningful and timely patient insights, despite their best intentions and strong desire to do so. Part 1 of the project also identified three knowledge gaps that need to be addressed if staff are to use PE feedback more effectively:

- Whose remit is PE?
- Which types of feedback should frontline teams use?
- How can narrative feedback be used to guide improvements to care?

Whose remit is PE?

The concept of PE is very broad: it refers to the continuum of care a patient receives, not just their encounters with individual clinicians (Wolf et al, 2014). As such, it falls under the remit of *all* the staff groups with whom the patient comes into contact.

Continuity and consistency of communication between these groups has been identified as important (O'Hara et al, 2018). As cross-discipline collaboration is essential, it is necessary to understand how this can be achieved in practice.

Which types of feedback should frontline teams use?

It can be difficult for frontline teams to know which types of PE feedback to consider, as so many are available. Marsh et al (2019) identified 37 types, including:

- Quantitative surveys that are collected infrequently, such as annual surveys;
- Qualitative patient comments and complaints;
- Online reviews;
- In-depth, qualitative (narrative) feedback – for example, patient stories and insights from experience-based co-design;
- Short surveys that are continuously collected, such as the FFT.

These types may present challenges: quantitative surveys or the FFT tend to reveal organisational trends but do not contain the detail required to inform change, while complaints, comments and online reviews describe one-off events from which it is difficult to generalise. Narrative feedback appears to offer most potential.

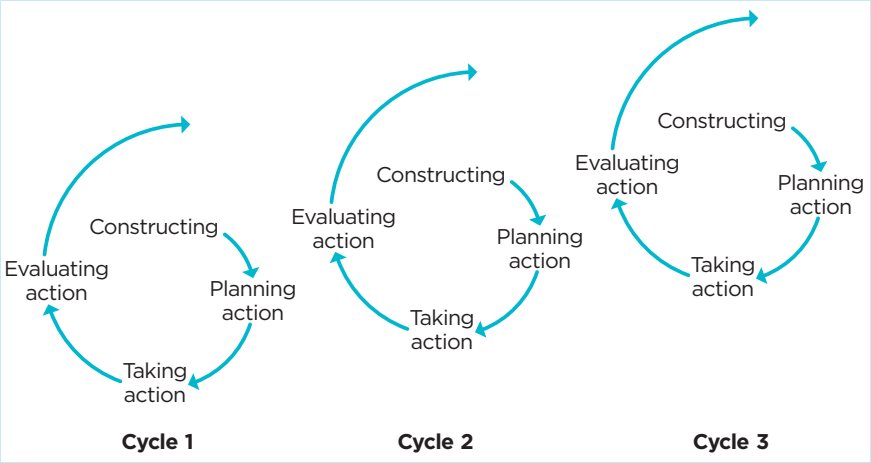
How can narrative feedback be used to guide improvements to care?

There are a small number of existing frameworks that guide the use of narrative-based feedback to improve frontline care. Bate and Robert's (2007) experience-based design approach uses recorded interviews or observations with both patients and staff to trigger discussions about redesigning and improving services; the participants are then regularly brought back together to review and reflect on progress. Evaluations show this approach is successful due to its highly participative nature, but it is lengthy and resource-intensive, which can be a barrier to its use (Donetto et al, 2014).

Two potentially shorter approaches are NHS Education for Scotland's Always Event project (Bit.ly/HESAlways) and NHS England's 15 Steps Challenge (Bit.ly/NHSE15Steps). Both collect PE feedback through group discussions or observations, then bring staff together to agree on improvements. Both approaches advocate the use of improvement methods, such as Plan, Do, Study, Act (PDSA), as suitable ways to decide on and implement changes but they provide little detail on how the feedback collected informs PDSA.

At BIHR, our project sought to respond to these challenges by developing a way of using PE feedback that is informed by the fundamentals of improvement science and requires a more nuanced approach than PDSA cycles alone. W Edwards Deming, often considered the 'father of PDSA', has, as reported by Langley et al (2009), also recognised that in addition to data, successful change requires attention to motivations, psychology and context. We, therefore, ensured the toolkit provided easy-to-follow, practical guidance on how to bring together busy staff members to work with narrative feedback to improve care; the guidance was intended to be applied in a variety of NHS contexts.

Fig 1. **Action research framework cycles**



Source: Coghlan and Brannick (2014)

Developing and testing the toolkit

To design and test the Yorkshire PET, we used Coghlan and Brannick's (2014) action research framework for organisational change (Fig 1). This approach brings together academics with practitioners who are directly affected by a problem; as co-researchers they investigate potential solutions through repeated cycles. This allows the practitioners to learn what works best practically for them, and the academics to glean and share theoretical insights. In our project, the co-research team comprised patient representatives as well as the academics who had conducted the research in part 1 alongside frontline teams and heads of PE from six wards across three NHS trusts.

The wards involved in the project were chosen to reflect the diversity of specialties in an acute hospital trust and for their willingness to engage. In these wards, we approached staff members from a range of disciplines and levels; however, those who took part were predominantly in nursing-related roles (Table 1).

In the construction phase of the first cycle, the academics held three workshops with design researchers from Sheffield Hallam University to co-design solutions to the three identified knowledge gaps. This led to the creation of a prototype, which each participating ward agreed to test over the course of one year, meeting periodically to reflect on and revise it in line with Coghlan and Brannick's (2014) action research framework.

To help with this, the academics held interviews and group discussions with the staff and patient representatives at intervals to decide on the essential components of a successful process, learning from

Table 1. **The ward specialties and frontline staff who took part in the project**

Hospital	Ward type	Staff involved
1	Male surgical	1 ward manager 1 healthcare assistant
	Community rehabilitation	1 ward manager 3 nurses 2 occupational therapy staff 1 physiotherapist All healthcare assistants
2	Emergency department	1 ward manager 1 nurse 1 healthcare assistant
	Female medical (older people)	1 ward manager All nurses and healthcare assistants
3	Male surgical	1 ward manager 1 senior nurse
	Maternity	2 ward managers (midwives)

what was working and what was not. The designers used these reflections to continually refine the prototype into an effective six-step toolkit (the Yorkshire PET) for working with PE feedback.

Central to this toolkit is a visual depiction of six steps that were found to be essential components of success (Fig 2). Table 2 gives examples of what two of the wards involved in the project did for each step. These examples demonstrate why each of the six steps is so important, as well as the challenges posed to frontline teams wishing to follow this approach.

The main findings from test period are summarised below.

Collaboration is essential

The two wards detailed in Table 2 achieved significant changes to aspects of their PE feedback processes; this was due to the large number of people with varying roles the wards had involved in the project. For Ward A, multidisciplinary goal planning was already an embedded team approach to rehabilitation, so there was an existing structure through which the team could jointly develop its responses to feedback. It also benefitted from involving the trust's volunteer manager, who could match volunteers to the ward's needs, which included running craft sessions, playing music and access to a therapy dog.

Ward B already held regular awaydays for the whole nursing team, which provided a suitable forum for developing collective responses to PE feedback. The ward manager placed importance on involving staff in solutions and not dictating:

> *"For me, the most important thing is that all my staff are willing to do it wholeheartedly – not because* [they] *have been told to do it, because they believe in it."* (Ward manager, Ward B)

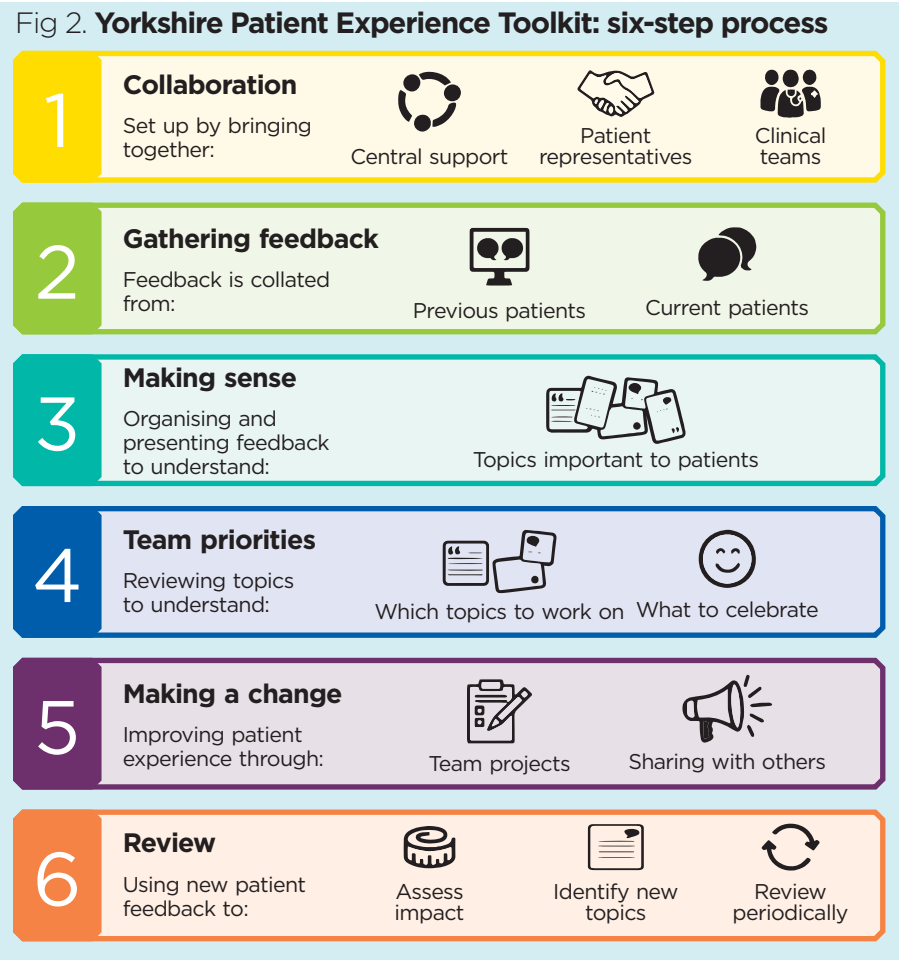
In contrast, the experiences of the other wards involved in the project demonstrated the restrictions posed by a lack of existing structures for cross-team working. Ward managers on the maternity ward said their PE feedback revealed contrasting messages between doctors and midwives. However, they chose to avoid this issue because it would require the involvement of other disciplines and they did not feel it was in their remit to resolve it. Instead, they chose to focus on the process of welcoming patients to the ward, as this was an area over which they felt they had more influence:

> *"This is our area and doctors aren't generally set to one area. I can cascade information to my own staff, but I don't manage the medics."* (Ward manager, maternity ward)

Frontline teams want detailed feedback from current patients

Although a range of data was already available about Ward B (through the FFT and patients' complaints and comments), the ward manager felt this did not provide an adequately thorough picture. In contrast, patient turnover was so low on Ward A that

Fig 2. **Yorkshire Patient Experience Toolkit: six-step process**



little data was readily available. The teams on both wards, therefore, asked their patient representatives to talk to current patients at the bedside and feed back any insights. The model they used comprised four open questions used in conversation-style interviews. Over 1-2 weeks, the representatives on both wards spoke to approximately half of the patients about what was important to them about their experience on the ward. The responses were collated and key themes identified.

Across the two example wards, as well as on two others involved in the project, staff were extremely impressed with the information these interviews provided. The approach was seen as practical and credible due to its independence; there was a belief it had really captured patients' perspectives. However, not all teams wanted this feedback: the emergency department (ED) was something of an anomaly in that the team routinely collected so much feedback – over 1,000 FFT comments per month – it did not want any more. Instead, it wanted to categorise the information it already had. FFT comments are not routinely categorised so this was a lengthy process and, although it was possible to develop categories, they were very broad and lacked detail.

Giving feedback to staff is emotive

On Wards A and B, the PE feedback collected by the patient representatives did not critique what staff were or were not doing but, rather, expressed patients' and relatives' emotional needs. The project team found that presenting this type of complex, emotion-rich feedback to front-line staff was difficult: staff expressed a range of emotions, including:

- Defensiveness – *"That is not our fault", "We know all that, but it's the way things are"*;
- Sadness – *"I just wish we could spend more time with* [patients]*"*;
- Annoyance and frustration – *"There will be no money to help with that"*.

The patient representative on Ward B noted that:

> *"When we had the meeting I was a little bit sad about the fact that the nursing staff felt they had failed patients in some way, because patients were saying 'I can't ask the question because everyone is too busy'. However, it wasn't an intended criticism."*

Sensitive facilitation was required and staff needed time to consider how things could be improved in the context of sometimes large and complex issues that were beyond their control.

Small-scale testing can help embed improvements

Ward A set a target of having communal lunches for 50% of patients. After staff sourced an adequate dinner table and chairs, this target was quickly met and could be increased. Ward B first trialled PE rounds with nurses but, as the nurses could not reliably find time for this, healthcare assistants were mentored to do the rounds using the PDSA approach.

The ED deemed the PDSA approach unfeasible due to its incremental nature. As a result of the large number of staff and patients on the ward, and the urgent issue of waiting times, the team chose not to use PDSA. Instead, it rolled out its initiative to provide information about waiting times using established means of whole-team cascading, such as emails and team briefs. However, winter pressures were so great that this approach did not work either; due to high levels of stress in the team, the initiative lost momentum.

Measuring impact is not always straightforward

Measuring impact is important for quality improvement, but a nuanced approach is required for PE. For example, on Ward A, while the team were engaged in testing communal lunches and volunteer recruitment, other activities arose spontaneously. Staff referred to a cultural shift focused on patients' social needs, which led to two staff members volunteering to run exercise classes on their days off.

Where initiatives had been successfully introduced on Wards A and B, follow-up interviews with patients indicated that responses were positive. However, particularly on Ward B, there were also clear signs that patients' needs remained the same and attending to PE was an ongoing, daily process. Patients and relatives remained older

Table 2. **Illustrative examples of the toolkit in action**

Toolkit step	Ward A: community rehabilitation	Ward B: female medical (older people)
1. Collaboration	● Whole ward team ● Patient representative ● Trust volunteer manager	● Whole ward team ● Patient representative ● Trust patient experience lead
2. Gathering feedback	● Little existing feedback available ● Patient representative conducted interviews	● Some existing feedback available ● Patient representative conducted interviews
3. Making sense (important topics)	● Loneliness, depression, concern for the future	● Anxiety about being in hospital and understanding implications
4. Team priorities	● More social activities for patients, starting with communal lunches ● Relaunching the ward's volunteering programme	● Giving patients and carers regular opportunities to ask questions ● Recruiting volunteers to talk to patients
5. Making a change	● Frontline staff set up communal lunches immediately ● Volunteer manager recruited people to run activities ● Ward staff started running exercise classes	● Healthcare assistants began daily patient experience rounds for patients and carers ● Patient experience lead helped recruit volunteers for the ward
6. Review	● Fewer reports of depression ● Activities were well received	● Same issues persist, but patients value the healthcare assistants' input

Ward A is a small community rehabilitation unit in a semi-rural, affluent location; it has 12-14 beds and patients can stay for several weeks. Ward B is a high-turnover medical ward that is mainly for older females; it is based in a large inner-city university hospital.

people who were anxious, and staff remained busy. The ward manager highlighted the pervasive nature of these issues and felt that regular PE feedback – even that which raised recurrent topics – helped to keep staff focused on patients' needs:

> *"You need to be reflecting all the time because, sometimes, people just become really task orientated when it becomes busy."* (Ward manager, Ward B)

Discussion

The toolkit's testing phase, particularly on the two example wards, demonstrates that it is primarily a people-centred approach that is not principally focused on data collection or data management. It was developed and tested to address the three pervasive questions about whose remit it is to conduct PE, the type of feedback that frontline teams should use and how narrative feedback can be used to guide improvements to care.

The answers provided by the testing phase pose particular challenges that have not received adequate attention to date; these are discussed below. If PE falls under the remit of all health professionals, organisational structures and resources need to be developed to facilitate collaborative working. Wards A and B had existing structures that were supportive of this, but the other four test wards did not. Nurses may be well placed to lead on this, because they are firmly linked to one ward while other health professionals are not; however, others need to share the agenda because patient concerns are complex and affected by everyone involved.

If staff need detailed narrative feedback that reveals patients' needs more than they need numerical and historical trends, this raises questions about the current focus on data collection and management systems such as the FFT (Roberts et al, 2018). It also raises questions about the NHS's ambitions to invest in data systems that triangulate information from multiple data sources. Our project demonstrated that simplicity appears to work: volunteers can collect meaningful insights by talking with patients. By applying the principles of qualitative analysis, these insights can be collated into themes that are easy for staff to understand. It also appeared important that patients' relational feedback – for example, expressing feelings – be kept intact and not converted to numbers or ratings.

Due to the complex, emotion-laden messages contained in PE feedback, the way staff are engaged to respond requires attention. Traditional cascade methods, such as emailed updates, may be appropriate for straightforward instructions about numerical data but this type of feedback is different. Instead of viewing it as data, it may be helpful to regard it as *"soft intelligence"* (Martin et al, 2015) that does not provide clear instructions but gives staff a chance to question their assumptions about being a patient on their ward and how they could improve things. This requires opportunities for staff reflection, engagement and ongoing moral support.

> ***"Collecting feedback periodically can help measure the impact of any changes and reignite empathy among staff"***

If facilitated and supported, staff can become empowered, and even enthusiastic, to do all they can to respond to patients' needs; however, the nature of some of the issues means new ways of measuring impact need to be developed. Patients may always have anxieties, but collecting feedback periodically serves to measure the impact of any changes and reignite empathy among staff.

Leading on from these is a broader challenge: people-centred agendas require people-centred development processes. The independent evaluation that took place alongside the development of this toolkit revealed the need for skilled facilitators to support teams through the six steps; in this project the academics engaged, motivated and guided the teams through some of the more technical aspects, such as feedback analysis (Mills et al, 2019). Overall, we found the toolkit was not a document that frontline teams could 'take off the shelf' and use but, rather, a guide for supportive staff – for example, quality improvement or PE leaders – to use in their roles.

Conclusion and future plans

The toolkit's six-step process is perhaps deceptively simple, as it requires no complex data management system or statistical analysis. However, it involves people-based processes of collaboration, talking, listening, identifying themes, reflection and empathy; furthermore, these are required in the strained environment of the NHS, where staff–patient relationships often suffer (Ball et al, 2014). Frontline teams, therefore, need significant support and our next steps will be to identify people and test ways to provide this. The Improvement Academy has launched a PET Coaches Network for Yorkshire and Humber, designed to equip staff from teams such as quality improvement or PE who use the toolkit in their trusts with the skills and resources to support frontline teams to work through the six steps regularly and effectively. **NT**

● The toolkit was developed as part of a research project funded by the Health Services and Delivery Research (HS&DR) Programme of the National Institute for Health Research (NIHR). The toolkit's continuing development is supported by the NIHR Applied Research Collaboration Yorkshire and Humber. The views and opinions expressed are those of the authors and do not necessarily reflect those of the HS&DR Programme, NIHR, NHS or the Department of Health and Social Care.

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