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The Patient Feedback Response Framework – Understanding why UK hospital staff find it difficult to make improvements based on patient feedback: A qualitative study

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ABSTRACT

Patients are increasingly being asked for feedback about their healthcare experiences. However, healthcare staff often find it difficult to act on this feedback in order to make improvements to services. This paper draws upon notions of legitimacy and readiness to develop a conceptual framework (Patient Feedback Response Framework – PFRF) which outlines why staff may find it problematic to respond to patient feedback.

A large qualitative study was conducted with 17 ward based teams between 2013 and 2014, across three hospital Trusts in the North of England. This was a process evaluation of a wider study where ward staff were encouraged to make action plans based on patient feedback. We focus on three methods here: i) examination of taped discussion between ward staff during action planning meetings ii) facilitators notes of these meetings iii) telephone interviews with staff focusing on whether action plans had been achieved six months later. Analysis employed an abductive approach.

Through the development of the PFRF, we found that making changes based on patient feedback is a complex multi-tiered process and not something that ward staff can simply 'do'. First, staff must exhibit normative legitimacy – the belief that listening to patients is a worthwhile exercise. Second, structural legitimacy has to be in place – ward teams need adequate autonomy, ownership and resource to enact change. Some ward teams are able to make improvements within their immediate control and environment. Third, for those staff who require interdepartmental co-operation or high level assistance to achieve change, organisational readiness must exist at the level of the hospital otherwise improvement will rarely be enacted. Case studies drawn from our empirical data demonstrate the above. It is only when appropriate levels of individual and organisational capacity to change exist, that patient feedback is likely to be acted upon to improve services.

1. Introduction

The last decade has witnessed an explosion in the collection of feedback from patients about their opinion of healthcare services throughout many countries across the world. This activity had largely taken place in the United States, Europe (particularly the UK) and Australia (Davidson et al., 2016; Edwards et al., 2015; Gleeson et al., 2016). The methods used can be both quantitative and qualitative and range from the level of large, national surveys through to the micro level of local patient narratives of their journey through the hospital system (Health Foundation, 2013). Other methods of gathering patient feedback may include: focus groups with patients, patient panels, official complaints and compliments, feedback delivered in real time via postcards or electronic kiosks, postal and online surveys. Recently, social media and websites such as Patient Opinion in the UK allow patients to give feedback in an unsolicited manner. Patient feedback through all the above channels, and many more besides, can relate to several important aspects of a patient's care; most noticeably patient

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experience, safety and quality. Integral to a high quality patient experience in hospital are: efficient processes, good clinical outcomes, the physical environment, how patients felt about the care they received and how staff interacted with them (NHS Confederation, 2010). A growing international body of evidence suggests that patient experience, safety and clinical effectiveness are inextricably linked (Doyle et al., 2013).

Despite the wealth of feedback now available to healthcare services, there is little evidence that this feedback has led to improvement in the quality of healthcare (Coulter et al., 2014). A review of the UK National Inpatient Survey concluded that "simply providing hospitals with patient feedback does not automatically have a positive effect on quality standards" (DeCourcy et al., 2012). Yet, there appears to be an assumption that merely giving staff feedback from their patients will drive ward based improvements (Reeves et al., 2013), with the complexity of how hospital staff manage to turn feedback into concrete improvements largely neglected. Indeed, the emphasis until recently has been on data collection in and of itself rather than data being used to improve the quality of care (Reeves et al., 2013).

Several reasons may explain why change could be difficult for clinical staff to achieve in relation to working on issues which patients have identified. Using data sources to change practice demands creativity and skills from staff who may have had little or no training in quality improvement and currently there is a tendency to present staff with data and expect change to happen as a result (Gkeredakis et al., 2011). Clinicians may be mistrustful of the data, defensive, merely lack interest (Asprey et al., 2013) or may not wish to claim issues as their own (Robert and Cornwell, 2013). Cornwell (2015) writes that improvement work based on patient experience data often draws attention to the attitudes and behaviours of frontline staff, which can cause anxiety amongst individuals. Until recently, there has been an unspoken but widely held belief by some healthcare professionals that providing a good patient experience is considered perhaps a luxury or 'nice but not necessary' (NHS Confederation, 2010).

At the level of the healthcare organisation, meso and macro factors come into play which may explain why it is difficult to enact change based on patient feedback. Dixon-Woods et al. (2013) articulate the difference between 'problem sensing' and 'comfort seeking' behaviours by hospitals. Problem sensing involves seeking out weaknesses in organisational systems by making use of multiple sources of data, including soft intelligence. Comfort seeking requires reassurance that all is well and that the organisation looks 'good' externally. When a hospital organisation tips towards comfort seeking behaviours, "data collection activities were prone to being treated by sharp end staff as wearisome and fruitless accountability exercises". The relationship between how frontline ward staff and executive board members consider patient feedback is said to be problematic in some organisations. A focus on surveys and targets may have "contributed to a tick box or compliance mentality" lulling hospital boards into thinking they were paying attention to patient experience (Robert and Cornwell, 2013) when the situation on the ground is somewhat different. Furthermore, there is said to be a 'chasm' between hospital management and frontline clinicians with the former investing heavily in providing the means to collect patient feedback but providing little structure in how the latter can act on this data to improve patient experience (Rozenblum et al., 2013). It has been said that an ever growing battery of targets, tools, metrics and inspections simply allows organisations to measure how compassionate their staff are rather than the task of changing the culture to enable more compassionate care to be delivered (Locock et al., 2014). Expansion of metrics to measure quality, safety and experience could become counterproductive with the unintended consequence being that they "add more to the noise without amplifying the signal" (Martin et al., 2015).

In this paper, we bring together three linked concepts which have previously been employed in the theoretical literature on institutional change in healthcare and more broadly in organisational sociology. These are: normative legitimacy (NL), structural legitimacy (SL) and organisational readiness (OR). We sought out conceptualisations of the link between the actions of individuals with their wider organisational context, and the ways in which they may navigate this complexity. We were interested in this link because the growing agenda for patient feedback to be used to improve services is not necessarily supported by healthcare organisations' dominant procedures and processes (Rozenblum et al., 2013). Equally, interventions designed to promote patient experience, quality and safety may often be targeted at specific individuals or groups to lead on, but ultimately they seek to effect change at a whole-system level, requiring cooperation between actors in different, often quite disparate parts of a healthcare organisation (Benn et al., 2009).

We looked to emerging interpretations of institutional theory to assist us. Macfarlane et al. (2013) states that the tendency in institutional theory has previously been overly deterministic, focusing on the influence of structure at the expense of individual agency, so that the structure exerts a particular logic and individuals will seek to maintain this status quo. With the advent of concepts such as 'institutional entrepreneurship' (Battilana et al., 2009), there is recognition that some individuals are not confined by the status quo, and do attempt to transform their organisations from within. Macfarlane welcomes the application by Lockett et al. (2012) of this concept to healthcare and their use of the concepts of legitimacy to understand the behaviour of individuals with respect to transforming their own contexts and institutionalising new agendas which they support. Lockett et al argue that a subject's position in an institution will vary depending on two types of 'legitimacy' that they hold. The first is their 'normative legitimacy' (NL) which Lockett defines as a "moral orientation being based on the ability to convince others of 'what ought to be' or 'what is the right thing to do"'. The second is their 'structural legitimacy' (SL) relating to "the power that emanates from professional hierarchy and jurisdiction" and this element will affect a subject's chances of effecting change. We note that Lockett's use of these concepts is a divergence from the original offering of Suchman (1995) who introduced concepts of legitimacy to organisational studies in order to understand whether or not the actions of an organisation as a whole are viewed as socially acceptable within dominant societal structures and norms. For our purposes, it is Lockett's application to the individuals within organisations that we draw upon in order to begin to unpick where action for change arises within our case study.

Lockett's proposal goes someway to understanding the behaviour of individuals and how their actions relate to the context they find themselves in. However, we believe that an additional layer can be added to enhance understanding of the relationship between an individual subject's position and the organisation as a whole. This especially relates to understanding the link between multiple members of an organisation (often from different divisions/ services) who need to come together collectively for a cross-department agenda such as improving patient experience. We propose that Weiner's (2009) conceptualisation of 'organisational readiness to change' (OR) is helpful here. This refers to the extent to which there is a collective, or shared "resolve to pursue the courses of action involved in change implementation". Crucially, this collective resolve needs to be perceived as such by whoever is leading the change - they need to believe they will find support to be effective in their efforts.