Research into patient experience feedback is a relatively recent phenomenon that gathered pace in the 1990s. Research into how healthcare providers use this data to improve services is at an early stage. A themed review of current research on patient feedback was conducted on behalf of the National Institute for Health Research, providing evidence to influence debate, policy and practice on the use of patient feedback data (Maxwell and Lamont, 2019); this article summarises its key findings. The full review can be found online at Bit.ly/NIHRFeedback.

Evidence shows that patient experience feedback can shape services to better meet patient needs. It results in patients using services efficiently and being more able to use clinical advice, and it can positively affect length of hospital stay (Doyle et al, 2013). Good patient experience is, therefore, seen as a central outcome for the NHS, but there are different ideas about what constitutes patient experience, and feedback is collected in different ways. Both patients and staff want patient feedback to be heard and acted on, and the NHS has clear policies to encourage this. Doing this in practice, however, is complex and challenging.

Reasons for collecting patient experience feedback

The different purposes of patient experience data direct the type of information collected, the way it is analysed and how it is subsequently used. For some healthcare staff and policy makers, feedback helps assess service performance against expectations; for others its primary purpose is to understand and respect individual experiences while, for others still, it is to improve services. More detail on the purposes for gathering such feedback are outlined in Box 1.

For patients and the public, there may be other purposes – for example, sharing their experiences with each other. Hearing about others’ experiences of a health condition could influence a person’s own health, through the sharing of information and support (Ziebland et al, 2016).

Although surveys have been developed to measure patient experience, this has not been very effective at improving care
Some people also see giving feedback as a form of public accountability for the service (Powell et al, 2019).

Sometimes patients’ intended purpose for their feedback is not matched by the way care providers use it. Many patients want to give praise and have two-way conversations about care, but healthcare providers can focus on complaints and concerns, meaning they unwittingly disregard useful feedback (Weich et al, 2020).

How is patient experience feedback collected?
Numerous studies suggest healthcare staff are keen to obtain credible feedback. However, they do not always know how to make the most of the diverse range of data collection methods (Fig 1) and unsolicited feedback available.

Currently, the NHS expends significant energy and money on collecting large amounts of patient feedback, particularly through surveys and the NHS Friends and Family Test, with less attention paid to whether this provides the information that is necessary to improve practice (Weich et al, 2020).

Issues with collecting feedback
Collecting feedback requires considerable sensitivity. Healthcare staff often express concerns about asking vulnerable people to give feedback (Speed et al, 2016). In addition, Weich et al (2020) found that staff felt inpatient mental health settings were an inappropriate place to obtain feedback because they did not have enough time to spend with people. People with long-term conditions may have pain or mobility restrictions that make it difficult to give feedback, and there are also issues for people whose first language is not English (Sanders et al, 2020). Graham et al (2018) also noted the potential for sampling bias from staff, who can select patients they think are most suitable to provide feedback.

Patients may value anonymity and reflection space when giving feedback after a care episode, sometimes for fear of the consequences while still receiving care; however, Sheard et al (2019) have reported that staff want real-time feedback. Healthcare staff may also often want an overview or an average figure, but there was a consensus among the steering group advising the review authors that people are more likely to give feedback if they are either very pleased or very unhappy, than if their feelings are neutral. This means there is a U-shaped distribution of responses, so using averages can be misleading.

Despite the desire for patients to tell their stories in their own words, the challenge of managing large volumes of free-text feedback prevents its widespread use. However, there are automated tools available that can analyse free-text feedback to identify themes (Sanders, 2020; Rivas et al, 2019).

A developing area of patient experience feedback is digital platforms such as iWantGreatCare (iwantgreatcare.org.uk) and Care Opinion (careopinion.org.uk) but a vast amount of online feedback is unseen by trusts – either because they are not looking in those places or because they do not think of them as legitimate feedback channels (Powell et al, 2019). Healthcare staff are often unsure where the responsibility lies regarding responding to online feedback.

What do healthcare providers do with feedback?
The journey from data to impact does not follow a linear path and partly depends on whether the people involved have the authority to act in a meaningful way (Donetto et al, 2019). Where there is no recognised system or person to act, change can falter.

Sheard et al (2017) stated that, to effectively use feedback data, staff need organisational permission and the resources to make changes. Staff in most of the wards they studied believed patient experience feedback was worthwhile, but did not have the resources to act on it and did not always have confidence in their ability or freedom to effect change.

Gkeredakis et al (2011) reported that simply presenting NHS staff with raw data will not lead to change. Clinical staff are busy and need easily accessible information; the way they respond to formal feedback is influenced by its format: for example, infographics are particularly helpful (Rivas et al, 2019; Graham et al, 2018). Sheard et al (2019) found that senior ward staff are often sent spreadsheets of unfiltered feedback, but lack the skills they need to analyse it. This is compounded by a lack of time – staffing calculations do not factor in time to act on patient feedback.

Box 1. Purposes of gathering patient experience data

- Performance monitoring and assurance
  - Comparison with other healthcare providers
  - Monitoring impact of service changes
  - Informing commissioning decisions
  - Compliance with standards

- Shared understanding and information
  - Helping people make choices about services
  - Understanding problems in services
  - Public accountability
  - Increasing staff understanding of patients’ real-life experience

- Improvement
  - Improvement and redesign of services
  - Reflection on staff behaviours
  - Framing care as person centred, rather than task or outcome centred
  - Staff and patients involved in co-design of services

Fig 1. Methods of collecting patient feedback

- Surveys
- Comment cards
- Kiosk questions
- SMS questions
- Online ratings
- Public meetings
- In-depth interviews
- Focus groups/panels
- Patient stories
- Photovoice
- Ward rounds/observations
- Complaints/compliments

Source: Health Foundation (2013)

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Who uses patient experience data? Sheard et al (2019) found that data is most often used by management teams to:
- Assess performance and benchmark in line with regulatory body requirements;
- Make comparisons with other healthcare providers;
- Assess progress over time.

Donetto et al (2019) found that patient feedback from national surveys is often presented at corporate level, rather than individual unit level, which hinders local ownership. Lee et al (2018) studied how two NHS trust boards used patient feedback and found that, although they discussed it, it was not used as a form of quality assurance and did not lead to action.

There is often a disparity between data generation conducted by patient experience teams and decisions about care improvement that result from that data – which is more often the responsibility of nursing teams (Donetto et al, 2019). Sheard et al (2019) found that quality improvement teams are rarely involved in managing patient experience feedback; in addition, data collection is often outsourced – organisations may not receive support to evaluate findings and translate them into actions (Flott et al, 2016).

What gets improved?
There is a potential tension between ‘quick wins’ and more-complex improvement. Sheard et al (2019) reported that ward teams want to get information from patient feedback, and should recognise that staff may need specialist training and the confidence and skill, to act on patient feedback, and should recognise that staff may need specialist training and expert facilitation.

What should healthcare providers change?
Organisations should embrace all forms of feedback as an opportunity to review and improve care. They should learn from positive, as well as negative, feedback. Structured and unstructured online feedback is emerging faster than the NHS’s ability to respond. Organisations need to think about how they manage and respond to such feedback. They can also learn from this qualitative and unrepresentative intelligence: sometimes the outliers are more useful than the average.

Organisations should:
- Collect and analyse feedback in ways that remain recognisable to the people who provide it;
- Offer staff actionable findings;
- Engage staff and patients in co-design and analysis – this is likely to result in sustainable improvements at a local level.

Tools are available that can help with this (Box 2).

Patient experience data should be presented to staff alongside safety and clinical effectiveness data, and the associations between them should be made explicit

References
Flott KM et al (2016) Can we use patient-reported feedback to drive change? The challenges of using patient-reported feedback and how they might be addressed. BMU Quality & Safety; doi: 10.1136/ bmjqs-2016-005223.