Improving patient experience remains a hot topic for the NHS. Given the current pressures on NHS staff and resources, simply maintaining the quality of patient experience might seem like an impossible challenge, let alone improving it. However, studies have shown that staff who get involved in quality improvement (QI) initiatives that are genuinely patient-centred and front-line-led, such as experience-based co-design (EBCD), find it rewarding and motivating (Locock et al, 2014; Maben et al, 2012; Bate and Robert, 2007). It will be important to remember this as the NHS recovers from the coronavirus pandemic.

In Locock et al’s (2014) study of an accelerated form of EBCD, a senior lung cancer specialist nurse told the project advisory group that it was the most inspiring thing she had done in her career. The research team found this both uplifting and profoundly sad. People become nurses because they want to make a difference to people’s lives (and deaths), because they value caring, and because they are motivated to ensure people receive the best-possible quality of care. They do not go to work to provide people with a poor experience. However, often the system constrains what they can do, imposes other priorities, does not allow time for care and causes burnout. This, in turn, may lead frontline staff to act against their own professional values.

There is a growing evidence base that organisations that provide good patient experience also perform well against a range of other clinical and organisational measures, such as:

- Lower mortality rate;
- Lower rate of hospital-acquired infections;
- Shorter lengths of hospital stay;
- Fewer adverse events;
Clinical Practice

Research summary

The idea that good patient experience is an unaffordable luxury when compared with clinical effectiveness and safety, therefore, may well be misplaced. There is also increasing evidence that staff experience and patient experience are linked (Maben et al, 2012).

The NHS collects a great deal of data about patient experience. Much of the data is survey-based but some is qualitative, such as patient stories and invited feedback received through platforms such as Care Opinion (careopinion.org.uk). However, while a lot of information is collected, it is not necessarily acted on (Coulter et al, 2014). Staff on the front line may see repeated issues occurring but lack the confidence, authority or resources to turn this knowledge into improvement. Martin et al (2015) observed that qualitative experience evidence from narratives and observations is often particularly moving and motivating for staff, but is harder to analyse and understand than a set of survey results.

To try to address this gap, in 2015 the Health Services and Delivery Research programme of the National Institute for Health Research (NIHR) commissioned several studies. Most of these studies have now reported, and the NIHR has published a themed review of the evidence (Maxwell, 2020). One of the NIHR-commissioned studies explored how frontline staff use patient experience data for service improvement (Locock et al, 2020). Its aim was to understand how frontline hospital ward teams engage with patient experience data when encouraged to do so, what challenges they face and how they can be better supported to work on patient-centred QI. This article discusses the method and findings of one work package of this study.

Methods

The study took place over one year, from 2016 to 2017. We worked with frontline medical ward teams in six sites around the country, supporting them to engage with patient experience data and design their own improvement projects, and observing what happened. Initial training was provided at a two-day learning community for frontline team members. There was a second learning community halfway through the study period, where we shared initial observations and offered further support, and a final event to celebrate achievements and feed back results.

We deliberately included sites with varying degrees of experience in patient-centred QI work and a range of patient and staff experience scores. We were not expecting everyone to move at the same pace or achieve the same level of QI; rather we wanted to understand more about how staff in different settings engaged (or did not engage) with patient experience data, including what helped, what the barriers were, and what could help other sites in the future. We invited wards to determine for themselves who they wanted to have on their core QI team and what they wanted to focus on.

A total of 299 hours of fieldwork observations and 95 staff interviews were undertaken across the six sites by a team of three ethnographers. Data and emerging findings were shared iteratively between the ethnography team and the lead investigator. Detailed case descriptions were prepared for comparative case study analysis, and the data was coded and analysed thematically. Alongside the holistic case study ethnography work, the team considered realist explanations of what worked for whom and in what circumstances emerging from the findings.

Results

A full report of our findings is available online (bit.ly.locock2020). In this article we highlight one aspect of our findings and its relevance for nursing: the role of team composition and diversity in patient experience QI work.

While all teams successfully implemented some patient-centred QI projects, all identified various factors that affected their ability to use and act on patient experience data. These included even relatively small amounts of resource (for example for creating welcome packs for patients), physical space to hold meetings or space in the day given busy schedules; skills and confidence in analysing patient feedback and determining action; whether staff felt they had the authority to put plans into action; and the degree of wider organisational support and encouragement (Box 1).

As we analysed our findings, an unexpected pattern began to emerge: teams that included a wider mix of disciplines and range of seniority seemed to make more progress in overcoming some of these obstacles than teams with a narrow, undisciplinary membership, regardless of their original starting position. Team composition seemed to be more helpful in explaining the results than contextual factors, such as past performance or recent history within each site. For example, the study included two sites, which had both recently faced challenging inspections and poor performance ratings. However, the site with a very mixed QI team pursued a much more ambitious and wide-ranging set of QI activities than the other, which comprised only nursing staff of a similar grade.

Across the six teams, there was substantial variation in professional role, discipline, level of seniority and clinical/non-clinical experience. Two undisciplinary teams consisted almost entirely of nursing staff from similar, relatively senior grades, whereas the remaining four teams comprised a mix of clinical and non-clinical staff, from healthcare assistants and ward clerks to senior managers and consultant physicians.

Senior staff were useful in being able to mobilise organisational support, draw in extra resources and exert leadership for change. For example, one senior doctor helped the ward nursing team write a bid for funding, and another instructed junior doctors to become actively involved in the QI project. Different disciplines also added strengths to the teams: in one case the involvement of a hospital pharmacist led to a new direction for the project.

Healthcare assistants and ward clerks also brought distinctive input. In one site, the role of a healthcare assistant-grade activities coordinator was pivotal. His creativity and close, informal relationship with the patients on the ward were influential in planning and designing improvements. In another site, the ward clerk contributed to interventions to change ward processes and resources to improve communication and relieve patient boredom.

All the case study sites in our sample had a designated patient experience office. Some wards chose to include members from this office in the core QI team, while others chose to restrict membership to frontline ward staff only. In one site, the ward team set aside space for a seconded member of the patient experience team, in Box 1. Factors affecting use of patient experience data

- A lack of resources to undertake even small interventions, such as printing or making welcome packs for patients
- Problems finding both time and physical space to hold meetings
- A lack of skills and confidence in analysing patient feedback and determining action
- Staff uncertainty around whether they had the authority to put plans into action
- The degree of wider organisational support and encouragement
effect co-opting them to the forefront and drawing them into their circle. By contrast, in other sites – particularly the two with undisciplinary teams – we observed a degree of distance and even mistrust between the ward team and the patient experience team. Some frontline staff seemed to feel unable to ask for help and were critical of the patient experience team for not visiting them and getting involved; others appeared to want to keep ownership of the project to themselves. Patient experience office staff thought they were unwelcome or felt it was not their place to do outreach to the ward; they expected staff to ask for help if they wanted it. The physical boundaries of the ward appeared to be an impenetrable barrier to both parties.

Discussion
While there is considerable evidence about what is needed for effective teamwork in healthcare generally, there is less evidence about how QI teams work and how this differs from normal clinical multidisciplinary teamworking. In their review, Rowland et al (2018) noted: “These teams are often ad hoc collections of various professions and/or occupations, working together in time-limited ways to accomplish specific QI aims. Much of the QI enterprise relies on the ability of these teams to identify a problem, design a solution, lead tests of change and implement a sustainable quality plan. Despite their pivotal role, little scholarly attention is paid to the processes of these teams.”

Rowland et al’s (2018) review found consensus among authors that QI teams should be composed of multiple professions. However, they observed that the reasons for this kind of composition were often left unstated, and recommended further research into the impact of interprofessional representation on QI teams. Reed et al’s (2018) ethnography of QI projects may help explain the dynamics at work here: they found high-performing teams “tended to be less hierarchical, where the views of all team members were listened to and valued, and people were empowered to explore and solve problems”. We suggest that team composition and diversity may help explain why some teams in our study were able to make greater progress and overcome difficulties more easily than others. If a team is more diverse, it can call on a wider range of skills, networks, ideas, resources and authority to effect change and stimulate each other’s thinking beyond undisciplinary horizons. Furthermore, a mix of levels of seniority provides a rich variety of perspectives on patient experience. Our full report describes this range of physical and metaphorical resources as forms of what sociologist Bourdieu (1986) calls capital, for example:

- Economic capital, such as monetary resources and staff time;
- Cultural capital, such as skillsets and access to training;
- Social capital, such as networks and the ability to engage others in the organisation;
- Symbolic capital, such as status, prestige and authority.

Diverse QI teams are thus able to leverage a range of capital.

Strengths, limitations and recommendations of the study
Our study’s comparative, longitudinal case study design provided rich, in-depth insights into the dynamics of teamworking for QI in six sites. However, as with all qualitative studies, the sample is small and should not be taken as predictive of what would happen in all sites. Given that our goal was to explore process and relationships, rather than to make quantitative measures of change, we describe patterns rather than causal relationships in our data.

Despite the fact that we encouraged frontline teams to involve patients as core members of their QI teams, direct involvement of patients and relatives was minimal. It could be hypothesised that greater patient involvement would add further to a team’s stock of resources and creativity; therefore, we suggest that, when planning QI projects and setting up teams to deliver them, frontline staff think explicitly about different stakeholders and what they might bring to the team to strengthen its capital. Sticking to a trusted inner circle of undisciplinary colleagues may feel more comfortable and less risky, but assembling a more diverse team and recognising what others can contribute may result in greater creativity and inventiveness. In particular, we recommend seeking out the organisation’s patient experience team and actively inviting them to support local QI efforts.

As the NHS rebuilds itself after the shock and disruption of Covid-19, using the skills of all staff members to improve the quality of patient experience will be an important step. NT

References
Coulter A et al (2014) Collecting data on patient experience is not enough— they must be used to improve care. British Medical Journal, 348, g2225.