Reflections from Practice- 'Transforming Practice and Empowering Staff in the Use of Qualitative 'Friends and Family Test' (FFT) Data to Enhance the Patient Experience'

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Introduction

Having worked in the Patient Experience Team for the last two years, I was keen to take part in the James Paget Research, Evaluation and QI Scholarship Programme funded by NICHE with the main aim of changing staff perceptions. My main role focuses on the Friends and Family Test (I'll refer to this as FFT going forward for brevity), which put simply is a national way of gathering feedback from patients after using an NHS service in the form of a short survey. Its main aim is to gather feedback on what works well and where improvements can be made. This all sounds straight forward, yet research by Sheard et al. (2017, p. 20) in which they explore why it is difficult to make improvements based on patient feedback, suggest the following:

'There appears to be an assumption that merely giving staff feedback….will drive ward based improvement with the complexity of how hospital staff manage to turn feedback into concrete improvements largely neglected.'

In my experience there is often a pre-occupation on patient survey response rate statistics and although staff receive qualitative patient feedback reports; I wondered how easy staff found it to use patient feedback to implement actual improvements. After all, it is this qualitative data which allows us to hear the patient voice and thus make improvements in order to better meet the needs of the community based on their experience. It seems reasonable to suggest that if staff are spending time collecting qualitative data, entering it and analysing it; then the actual end point should be using it to bring about changes that benefit's patient experience, which will impact positively on the care relationship. I therefore decided to explore the following question to try and make the qualitative data collected have real impact, as it is vital that FFT data does not become something simply collected to 'tick' a box.

How can staff use qualitative data to bring about patient suggested improvement and truly improve the patient experience?

I decided to choose a quality improvement approach so that continuous improvement became embedded within the culture of the ward or department. Locock et al (2020, p.71) suggest 'the act of undertaking quality improvement activity could in itself improve staff morale, appealing to staff's intrinsic motivation to provide good patient care.' In essence, staff motivation and morale are essential ingredients and as part of the quality improvement approach, the aim was to underpin an embedded, evolving culture of change driven by staff motivation for continuous improvement in terms of a positive workplace culture and patient experience. 'Collective' leadership was considered important here and West et al. (2014, p. 11) suggest a range of factors influence staff engagement including, 'promoting a positive climate, recognising staff contributions, providing information,

giving helpful feedback, supporting staff innovation, promoting transparency and developing trusting relations.' These factors were built into the quality improvement cycle in order to motivate staff, make them feel involved in the process, develop a desire to make changes and indeed improve their own working environment through developing the patient experience.

Reflective Discussion

Creating a change in culture is not easy! Whilst there were some successes, there were many barriers which proved difficult to overcome, which I will now reflect upon. To aid me in this I will use research by Cardiff et al. (2020) in which I will use their 'guiding lights' as lenses for reflective discussion.

Whilst the project did have a measurable impact on staff feeling they received feedback and that there was a shift towards a culture that made patient suggested changes, this was somewhat offset by the staff resistance to change barrier. The lens 'collective leadership' (Cardiff et al. 2020) is useful here. As already discussed collective leadership was built into the quality improvement cycle. Yet in the project did ward leaders truly have the training to overcome staff resistance to change and involve them in a process in which staff felt 'valued, respected, listened to and heard?' (Cardiff et al. p. 10) Yes, the quality improvement model built in the need to have a monthly staff meeting to discuss how to implement patient suggested changes, but a barrier was actually finding the time to build these meetings into a busy, demanding schedule. A barrier identified was the need to have training and here I fully agree. Indeed as part of future quality improvement training for leaders there needs to be a focus on how to involve ward staff in order to motivate them to feel part of the process in which their voices are heard and that they are able to implement ideas for change that benefit the patient experience as outlined by West at al. (2014, p.11) discussed earlier. Training can be seen as the sole answer, I was left wondering if embedding a culture that welcomes and acts upon patient feedback requires more than training alone, such as facilitation in the workplace that supports training and learning where care is experienced by patients and delivered by staff.

Major barriers identified in the project included a lack of communication in terms of feedback data and a lack of clarity in terms of roles and responsibilities. Sheard et al. (2017) critically question what the actual focus of collecting qualitative data should be. The lens 'living shared values' (Cardiff et al. 2020) is useful here in which values, beliefs, co-construction and bottom up and top down communication are key. Firstly trusts need to define what the purpose of collecting FFT data actually is and in my view it is not wholly about statistics, but how this data improves the patient experience at the interface of care. There therefore needs to be a focus on developing a shared understanding with all parties concerned. Communication is key and indeed as part of a quality improvement model there needs to be an understanding of how data is shared and actually acted upon and by whom. In terms of bottom up and top down communication it would be interesting to compare the views of different levels of staff to determine whether there is shared agreement about roles and responsibilities or whether there are some inherent misunderstandings, which indeed would be barriers to successful communication and would therefore need aligning. The use of staff Schwartz Rounds could be considered as a useful tool here.

In the final analysis of the project, staff called for clearer hospital policy on how FFT data is used to improve patient experience. As discussed, firstly there needs to be a discussion on the purpose of collecting FFT and how to ensure the patient voice for change is heard and acted upon. The lens 'safe, critical, creative, learning environments' (Cardiff et al. 2020) is useful here. Firstly I confess that I have changed my mind on how I originally envisaged the end quality improvement model. In reality it is not about each ward and department following the same quality improvement model, as

there are so many variations in terms of staffing and time etc. Whilst it is vital the purpose of FFT is clarified first and there is commitment to using this data to enhance the patient experience; in reality each ward and department should be supported to implement its own quality improvement model based on need, circumstance and context. This should be facilitated through staff quality improvement model training and workplace, embedded learning and should explore how a cycle of simple patient suggested changes can be implemented on the ground, including how patients will know we are responding to feedback through simple 'You Said, We Did' display. The quality improvement model should be regularly reviewed (perhaps co-constructed) by staff and there should be opportunities for staff to fully contribute and own the work. Here I call for the establishment of FFT champions in each ward and department i.e. a member of staff who can aid communication and help motivate staff in the value of FFT as a method to improve patient experience through feedback and encourage staff to be solution focused. However, we should be mindful in the words of Cardiff et al. (2020, p.8) that 'workplace cultures are not dependent on specific individuals,' rather a workplace culture that continually strives for development and improvement in which the patients voice is authentically 'heard' and acted upon.

Finally in the project, whilst staff felt FFT improved the patient experience; they felt it improved the staff experience to a lesser degree. The lens 'change for good that makes a difference' is useful here in which staff, 'experience joy from their work and are energised to develop and innovate for the good of others and self' (Cardiff et al. 2020, p.13). If we develop a shared understanding of what matters, listen and seek solutions to make positive changes to benefit patient experience and involve staff, then over time I believe this will benefit the staff experience, as surely NHS staff want to ensure that patients' needs are met and that they are working within a workplace culture that enable continuous improvement in care. Again it would be interesting to develop some Schwartz Rounds to evidence this and indeed provide some examples to further motivate staff.

Conclusion

My overall aim is to encourage NHS trusts to use their qualitative FFT data to really enhance the patient experience through a quality improvement approach. This is not easy and one model will not fit all. I hope that my project will spark debate and incite trusts to try to find solutions that listen to patients and staff and create a sense of motivation for continuous embedded improvement and learning in the workplace. Interestingly when conducting a literature review there appeared to be little research or case studies on how NHS trusts use qualitative FFT data to improve the patient experience, so I invite trusts to share their projects to overcome the barriers, motivate each other and allow the sharing of ideas which can be adapted as part of a quality improvement cycle approach. After all, it is this patient qualitative data that gives real insight, drives change and enables us to truly respond to patient needs.

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