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“Feedback is indeed a dainty dish to set before the Trust”: Comparing how online patient feedback is responded to and used across three hospital Trusts in England

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Abstract

Patients are increasingly reporting about their healthcare experiences in an unsolicited manner online. This emerging resource may offer valuable opportunities for organisational learning. Our study aimed to compare how online patient feedback was responded to and used for improvement in three hospital Trusts. Ethnographic data were collected across three hospital Trusts in England, recruited according to the way they responded to online patient feedback. Findings from three case studies were brought together using a reflexive thematic analysis approach, via a multi-case analysis. Three key themes were highlighted. Firstly, the organisational rationale for engaging with patient feedback influenced levels of compassion felt for feedback providers, and in turn, the extent feedback was valued and learned from. Secondly, multidisciplinary collaboration between patient experience teams and the wider organisation helped to disseminate ownership felt for feedback and overcome ‘contextual blindness’. Thirdly, the risk of patient feedback falling into an ‘abyss’ was reduced when staff prioritised learning over and above collecting and reporting data, and when managers disseminated a passion for improvement. Overall, online feedback was considered a courageous step into the unknown. However, these barriers could be culturally overcome. Our multi-case analysis demonstrates that there is still a way to go for some organisations to culturally embrace online patient feedback as a valued means to improve. However, we present five key suggestions to inform policy and practice and support the use and usefulness of online patient feedback for organisational learning.

Keywords

Patient feedback, patient experience, digital health, patient safety, qualitative methods, patient centeredness.

Introduction

Long after the founding of the NHS in 1948, patients were recognised as passive recipients of care in the UK.¹ However, more recently, patient insights are largely accepted as valuable and untapped resources, within a system of healthcare that is done *with* people, rather than *to* people.² Subsequently, healthcare policy and guidance has increasingly encouraged the alignment of healthcare services with patients’ needs and preferences (e.g., NHS Patient Safety Strategy, 2019³), and seen a national drive to collect feedback from patients via methods such as surveys and on-site feedback tools.⁴ ‘Patient-centred care’ has become a ubiquitous term and the era of “the participatory zeitgeist” is arguably upon us.⁵ This shift has been underpinned by two key rationales for patient involvement,⁶ recognising that not only does patient involvement serve as a moral obligation of healthcare services, but patients also offer credible insights to support improvements to the quality and safety of care. Drawing upon these rationales to varying degrees, Duschinsky and

Paddison⁷ noted key historical paradigm shifts that fostered the importance of patient experience in the UK. This included the early ‘patient voice’ movement derived from patient activism, the subsequent consumer movement emphasising patient choice, the ‘patient expertise’ stance which sought to recognise the value of patient insights, and finally, the ‘patients-as-auditors’ movement following scandals of poor-quality care (e.g., Francis, 2013⁸). Nonetheless, these were arguably, largely top-down trends in healthcare policy and realised in practice to variable degrees. Struggles to move from a provider-focused to a patient-centric culture remained for staff, with much of the original health services infrastructure in place designed to cater to paternalism.⁹

Dichotomous to a paternalistic approach to care, patients are increasingly reporting about their healthcare experiences in an unsolicited manner online. This important, emerging resource may offer organisations a low-cost and real-time opportunity to gain a clearer sense of how patients are experiencing services, what is working

well and identify areas requiring improvement. Despite the potential of this online ‘improvement resource’, research has highlighted policy and practice disparities, as staff often encounter difficulties in engaging with patient feedback as an improvement method,^{10,11} and there is a growing consensus that a focus on feedback collection without concomitant action is futile.^{12,13} The digital and public nature of online patient feedback may also present unique benefits and challenges, such as preserving anonymity, emphasising existing selection biases, incompatibilities with outdated IT systems and the need for skills and resource to interpret information. Additionally, staff responses to online patient feedback vary, based on the extent they are specific and personal, how much responders embrace the transparent nature of public discussion and whether staff suggest that the feedback had led to learning or impacted subsequent care delivery.^{14,15} Recently, three in-depth case studies were presented of hospital Trusts that adopted distinct approaches to responding to online patient feedback via the platform Care Opinion.¹⁴ The case studies explored the contexts in which organisations actively ignored or only engaged in generic responding styles online, delivered in corporate, formal ways, whereas others gave staff the freedom to improvise their discourse and engage in informal, transparent, and reciprocal exchanges with patients online. Based on the highlighted issues, the objective of this study was to use the three case studies as a foundation from which to compare how online patient feedback was responded to and used across the three hospital Trusts. Specifically, the following research questions were addressed:

- What is similar and different about the ways online patient feedback is used in practice across organisations that respond using distinct approaches?
- Why do the ways in which organisations respond to and use online patient feedback vary?

Methods

Ethical approval was obtained from the Faculty of Medicine and Health research ethics committee at The University of Leeds (no. PSC-444), and the study was drafted in accordance with the consolidated criteria for reporting qualitative research (COREQ).¹⁶ Authors have backgrounds in psychology, sociology, quality and safety, improvement science and applied health services research. A reflexive diary was kept, demonstrating how interpretations were formed and ensure that they were warranted by the data.

Care opinion (www.careopinion.org.uk)

Care Opinion is a not-for-profit community interest company. Formerly Patient Opinion, the site launched in 2005 and has since provided an online feedback platform for health and social care services across the UK. The

online platform is available to patients to provide unsolicited narratives about their experience of care, and representatives of provider organisations can respond. The site now hosts almost 600,000 stories of care experiences and is visited by about 150,000 users per month. Over 500 organisations subscribe to the service, paying an annual fee in return for access to platform features, training and support. Around 13,000 staff have accounts giving access to features such as alerting, responding, reporting and data visualisations. The service is promoted to patients and relatives primarily by healthcare staff themselves. Alongside the UK, it is currently available in Australia and Ireland.

Case selection

Three hospital Trusts were recruited to the study based on the way they responded to online patient feedback via Care Opinion, according to the study authors’ pre-identified typology.¹⁵ For context, as of 2022, there were a total of 215 Trusts in England, comprising acute, mental health, ambulance, specialist and community Trusts. Selection was both theoretically guided and determined pragmatically based on sites being situated locally within the English NHS (travel to and from within the day). Sites comprised a non-responding organisation (site A), an organisation who gave the same generic response to all feedback provided (site B) and an organisation that gave transparent, conversational responses to patients online (site C). Staff within the identified Trusts were initially approached via email. Once study sites were determined, initial interviews were arranged and snowball and opportunistic sampling methods were used to further recruit staff members who had, or may be expected to have, an interest in online patient feedback within each Trust.

Ethnographic methods

A focused ethnographic approach¹⁷ was adopted during a year of fieldwork from March 2019 to March 2020, via an iterative and continuous process of data collection, analysis and reflection aiming to interrogate and understand the ‘ordinary’ to gain insights into ‘extraordinary’ sociocultural contexts. During fieldwork, a total of 25 semi-structured 1:1 in-depth interviews were carried out with staff that were considered stakeholders in patient experience (7 interviews at site A, 8 at site B, 10 at site C). This included staff from the patient experience team, communication team, quality improvement team, volunteering, and frontline healthcare staff. Interviews followed an iteratively developed topic guide, helping the researcher to lead the conversation towards the research area while allowing unpredicted avenues of conversation. Interview duration ranged from 23-74 minutes (average 41 minutes). Alongside formal interviews, observations of practice and ad-hoc conversations helped to elucidate how online patient feedback was responded to and used in practice. Detailed field notes were kept, which included descriptive

and analytical reflections, first impressions, detailed information around noteworthy events, pictures, and diagrams to assist memory and sense-making, details of non-recorded discussions and copies of relevant information. Data were also collected from various relevant documentary sources including publicly available data and information provided by participants. For example, relevant reports, policies, and photographs that captured noteworthy events (6 source types at site A, 9 at site B, 20 at site C). In-depth findings relating to each individual site are reported elsewhere¹⁴ are summarised in Table 1 to enable the multi-case analysis to be viewed in context.

Multi-case analysis

To understand complex phenomena and evaluate similarities and uniqueness, it is important to consider

linked typical and atypical cases and draw higher-level conclusions, additional to exclusive case study analysis.¹⁸ Our multi-case analysis of three case studies¹⁴ was approached using a reflexive thematic analysis approach.¹⁹ Original data and case studies were read carefully to gain a holistic view and achieve immersion. Descriptive comments were made based on commonalities and differences between cases, and initial impressions of higher-level themes and significant extracts were highlighted. Broad candidate themes were identified on a semantic level using an inductive, bottom-up approach based on significant and common features, issues and concepts and refined via regular meetings with all authors. According to broad candidate themes, relevant data from all sources were coded, with significant extracts helping to define and evidence each theme. Where extracts fitted multiple themes, they were coded multiple times. Thematic

Table 1. Summary of sites

Site	Organisational responding type provided to patients on Care Opinion ¹⁵	Trust Characteristics (see ¹⁴ for a more detailed description)	Case study summary ¹⁴
A	Non-responder	An acute Trust in England which operated from two hospital sites offering a large range of acute services within the area and a number of specialist services beyond the area. The Trust employed around 8000 staff and cared for approximately 1 million patients annually. The most recent CQC rating was published in 2018, which rated them overall as 'requires improvement'. The Trust had 2 registered staff users on Care Opinion, one who had left the Trust and the other who did not self-identify with being responsible.	The organisation did not respond to or use online patient feedback as staff were busy firefighting volumes of concerns raised in other ways.
B	Generic responder	An acute Trust in England which served a population of over 250,000 people in the area, caring for over 61,000 patients in the hospital, 268,000 in clinic appointments and treating 78,000 in the emergency department. It also provided a range of district hospital services to the local community and surrounding area including emergency department services, outpatient clinics, inpatient services and maternity and children's services. A number of specialised services were also provided including cancer and surgical services, in conjunction with a local Trust. The most recent CQC report was published in 2018 and awarded them overall 'good'. The Trust had 0 registered users on Care Opinion, however, two Communications staff engaged indirectly via NHS.UK.	The Trust adopted a generic responding style and provided the same response to all online patient feedback due to resource constraints, fears of public engagement and the focus on resolving known issues raised via more traditional feedback sources.
C	Transparent, conversational responder	A mental health Trust in England providing mental health, intellectual disability and community healthcare services, with approximately 190,000 patients per year. The Trust employed approximately 9000 staff who provided a variety of services for people with mental health needs including secure mental health services. The most recent CQC rating was published in 2019 which awarded them overall 'requires improvement'. However, within the report their activity around online feedback was highlighted as an example of outstanding practice. The Trust had >890 registered staff users on Care Opinion across the hierarchy of the organisation including board members, the patient experience team and frontline healthcare staff.	The organisation provided transparent, conversational responses to patients online as part of a wider mission for transparency and described a 10-year journey enabling their desired culture to be embedded.

maps collated candidate themes, illustrating connections and clusters to find repeated patterns of meaning and iteratively refine until a consensus was reached. At each stage of analysis, decisions were discussed between authors and original sources were revisited to ensure they were grounded in the data. Conflicting accounts were taken note of, and where necessary, captured in the analysis. Analysis paid particular attention to the research questions while keeping unpredicted, but relevant themes. A detailed log of theme development and rationale was kept, comprising >45,000 words.

Findings

Our multi-case analysis compared how online patient feedback was responded to and used in three hospital trusts, highlighting three key themes, each with their own subthemes.

Why are we doing this? A determining factor

Our first theme considers the different rationales organisations had for engaging with feedback from patients, underpinned by a motivation to resolve individual concerns, to learn organisationally or a combination of the two. The organisational rationale seemed to have a ripple effect on a range of factors such as the perceived value of information, how it was processed and who was involved or excluded in those processes. Additionally, it catalysed the levels of compassion felt for feedback providers, the extent to which staff were supported and in turn, if feedback had any subsequent impact on future care delivery.

At site A the focus was on listening to individual patient concerns and getting answers quickly. With limited opportunities to influence organisational change, the central patient experience team saw their role as ‘resolution providers’. At site B, the focus was on logging, counting, and reporting feedback routinely. The central patient experience team saw their role as data processors and report generators, which often did not lead to improvement work. At site C, the focus was on responding openly, continually improving, and inviting further involvement. The central patient experience team saw their role as ensuring that listening and learning to patients was valued across the organisation, which was underpinned by many years of challenge and perseverance.

De- or re-humanising patient experiences

The focus on processing and reporting feedback at site B meant that the intricacies of human experiences were often lost. However, attempts to consider feedback more meaningfully were perceived as a powerful way of ‘re-humanising’ data, generating discussion, and setting bases for interventions. At site A, patient experiences were humanised to the centralised team they were in direct contact with. However, the team referred to encountering

difficulties establishing relationships with clinical staff who held deeper concerns regarding threat to their professional position or reputation, meaning that little changed. For some, this ‘de-humanising’ and disregard of patient experiences was a frustration.

“It’s about understanding what it’s taken for people to come to us in the first place. And for us not to then do them justice, I think it’s wrong really.” [Site A, Patient Advice and Liaison Service (PALS) officer]

At site C, online feedback was largely viewed as being provided with the intention of genuinely improving services and so the patient experience team encouraged staff to avoid assuming they knew how services were being experienced, but to learn from fresh perspectives. This helped to sensitise staff who were removed from the frontline to the human experiences of service users, and invite ongoing involvement work, which was considered not only valuable to inform learning, but also as a therapeutic exercise within the context of mental healthcare.

“Often when patients leave their feedback, they become much more involved with other work. That’s really recovery focused.” [Site C, Service improvement facilitator]

As part of organisational efforts to humanise patient experiences, a service user who informed changes via Care Opinion was invited to speak to senior leadership, which was powerfully received by the large audience. The service user recounted how their feedback had led to securing a valuable group for voice hearers and encouraged the reevaluation of blanket locked door policies.

*“I posted on Care Opinion... I reached out to you, longingly. A services manager on reading my post... had been positive, sensitive, caring. She had **listened**. More than that. She had **done** something... What I like most about giving feedback is that we become part of one another. Touch each other’s lives... Feedback is indeed a dainty dish to set before the Trust.”* [Site C, Care Opinion author and service user]

Multidisciplinary collaboration

Our second theme emphasises the importance of the relational aspects of patient experience systems. Nevertheless, multidisciplinary collaboration was not described as an easy undertaking. Each site developed different approaches to feedback ownership, and all felt there were opportunities to improve the way that staff learned from one another within and between teams, services, and organisations.

Feedback ownership

Site C’s distributed model of feedback ownership was a key way of fostering collaboration, requiring people at all levels of the organisation to understand the value in

engaging and responding to online feedback. Many, including all general managers, heads of service and team leaders were automatically assigned as Care Opinion responders, and were each asked to nominate a minimum of two additional staff, with no upper limits. This led to over 890 staff being empowered to take ownership of feedback, respond to service users online and be supported to learn, and aimed to alleviate concerns of the sustainability of the approach. The scale of the organisation meant that levels of engagement inevitably varied. Champions found that getting everyone on board was an ongoing challenge.

“Give ownership of feedback to teams... if you own it you’re more likely to feel responsible for it. It’s not the responsibility of the communications team, or the patient experience team, it’s your feedback... that’s a really personal way to use it.” [Site C, Involvement and experience officer]

The central patient experience team expected initial pushback from the Board in relation to this approach, however, members came to support their decision over time. The board were actively involved in the Trust’s engagement with Care Opinion and engaged with reports containing examples of complementary and highly critical feedback, alongside staff responses and action plans. Staff were encouraged to focus on collaboratively learning from, and responding to, critical feedback with frontline teams, over and above concerns that the feedback content itself may damage organisational reputation. This differed to the centralised approaches at sites A and B, where privileged access to online feedback was granted to a particular few.

Partnerships overcoming ‘contextual blindness’

Protected time for relationship building to achieve organisational learning was considered essential, but due to constraints, was often neglected, scarcely resourced and reliant upon discretionary efforts. Instead, intelligence obtained via online feedback was often kept exclusively by individuals with limited variation in underpinning values, skills, and expertise. To reduce the risk of parochial views at site C, lasting and strategic relationships were established between the central patient experience team and those including frontline staff, board members, quality improvement staff, volunteers, communications, organisational development, and the leadership council. Regular formal and informal multidisciplinary meetings enabled the sharing of learning, goals and alliances, and further disseminated the sense of responsibility felt for patient feedback. Nevertheless, it was a continuous challenge to ensure that these efforts remained a priority for people working in different roles, with competing demands.

“We’re almost constantly trying to have conversations with teams and promoting it. We use a lot of opportunities when we go in... identify some keen people... trying to up-skill and engage other staff

members. It can’t just be about me doing it.” [Site C, Service improvement facilitator]

Other examples of partnership included volunteers working closely with staff on a variety of tasks including co-delivering Trust induction, running lived-experience workshops, and collaboratively producing patient feedback reports. Specifically, volunteers worked with matrons and service users in secure forensic services to collect feedback using verbal and paper-based methods to subsequently publish via Care Opinion and on service notice boards, which were updated with responses and actions. This informed a range of changes including reviewing care plans and day services, increasing staffing levels and developing bullying interventions.

“Volunteers went on to the wards in our high secure hospital and chatted to patients about bullying that they had reported and we were able to get responses from the associate director and the director in forensic services and make changes.” [Site C, Volunteering and befriending lead]

Alternatively at site B, ‘contextual blindness’ meant that the patient experience team prioritised preparing reports of feedback collected via supported sources, yet consideration regarding the skills, time and resources required of frontline staff to engage with reports fell outside their remit. Additionally, decisions regarding how online feedback was organisationally managed were made by communications staff, based on assumptions of what others, such as frontline staff, wanted without explicit agreement.

“We would signpost to PALS but we don’t share or have any involvement in the negative stuff we pass on, so I don’t really know what happens to it? If someone has left a review, we don’t really want that to turn into a complaint. That’s our working assumption. I’m not sure if that’s what the patient experience team want or not? We haven’t really discussed that.” [Site B, Communications and digital manager]

Nevertheless, discrete teams unaware of Care Opinion were finding real value in engaging with alternative local online feedback forums.

“We’ve recently been doing some work with our LGBTQ women... These two lovely ladies were discharged home with their baby. We give a little discharge pack... but we also give condoms out. That was really interesting because they really took offence to that. But that’s just something that is done so routinely that it’s never been thought about before. And then you start asking yourself questions, “Well actually, why do we give condoms out?”” [Site B, Public health specialist midwife]

While collaboration efforts were growing at site C, staff at sites A and B shared how pressures had led to the discontinuation of opportunities to learn and referred to

being unaware of where similar teams were physically located, their responsibilities and the extent to which expertise could be shared. This was demonstrated by Patient Advice and Liaison Service (PALS) and frontline teams lacking a clear understanding of how each other worked.

“There used to be a PALS operational learning group type thing and we all used to join up and meet each other about once every two months to share practices and documents and things, but once again that’s gone out of the window.” [Site B, PALS officer]

The ‘patient feedback abyss’

Our final theme refers to the sense that organisations were often not learning from much of the patient feedback it collected. While site A were actively ignoring feedback sources, site B were well-intentionally listening and bringing attempts at ‘resolution’ for individual patients. Nevertheless, efforts were stymied by systemic obstacles in the way of purposefully acting upon what they were hearing, with limited learning at service and organisational level, and most falling into the ‘patient feedback abyss’. There were risks that patient experience teams were working tirelessly to keep pace with the data being collected and reporting patient experience information, largely to themselves and other senior staff, mistaking activity for the end goal of improvement. Reporting was also often viewed as a neutral presentation of patient experiences, yet risked stripping the original context, displacing meaning and silencing patient experiences, subsequently reducing the opportunities to improve. On the other hand, site C were able to maintain a clear focus on involvement and learning, with permission to do so from supportive management and internal policy. While each site was at different stages of online feedback engagement, there were catalysts of influence including the extent to which learning was prioritised and attitudes of influential individuals.

The ‘patient experience lag’

Online patient feedback was of interest to staff across sites, yet learning from it did not easily cohere with institutional infrastructure and processes designed to suit traditional feedback methods. Trusts were slow to adapt to patients’ needs, preferences and technology, and lacked formal infrastructure to manage feedback sources outside of those they created and supported. Despite Care Opinion being founded in 2005, it was considered a relatively novel feedback mechanism by those aware of the platform. Many working at the sharp end of care remained uninformed that some patients were engaging with online channels to provide their feedback anonymously. This was perpetuated by a lack of encouragement to monitor and respond to online feedback by senior leadership, despite many being theoretically interested to hear what patients were saying about them and their services, responding and improving. Even within site C, an organisation with over

890 staff engaged in listening and responding to online feedback, ensuring that all staff were aware and actively involved remained a challenge.

“It would be better if they could come via the more traditional routes. Because it’s an external website, you don’t always pick up on things... sometimes it is things that can be dealt with really quickly by PALS.” [Site A, Patient experience officer]

While site A largely disregarded online feedback, site B responded using standardised narratives redirecting patients to contact PALS, with an aim of absorbing low-level concerns to avoid formal complaints. Underlining the need for infrastructure to support engagement, site C had developed a public facing website interlinking with readily available Care Opinion infrastructure, supporting reporting and information synthesis activity.

The collecting vs. reporting vs. learning dilemma

All teams allocated limited resources across three core feedback activities: collecting data, reporting information and learning. These were generally perceived to be mutually reinforcing, yet often mistaken for one another and sometimes demonstrating incompatibilities. Those at site C who moved away from a core focus on collecting feedback were better able to prioritise listening, responding, and learning, over and above collecting and internally reporting data quantities. In contrast, the prioritisation of feedback collection at site A, alongside organisational reporting at site B, meant the ultimate goal of learning was easily lost.

“If somebody leaves feedback asking for a change, you’re given a golden opportunity to put it right... There’s been plenty of services with very positive feedback and as a result the service has been extended or commissioned again... Our staff are very keen and will engage in it if they can see results. Patients are very keen to leave feedback if they can see that it leads to change... it’s about a message that you’re not doing it for the sake.” [Site C, Involvement and experience officer]

Care Opinion functionality streamlined reporting processes, alleviating staff pressures to heavily invest in collection efforts or producing inefficacious reports. As such, reporting was recognised as a helpful way to raise awareness of service user experiences, yet remained a demonstration of, rather than substitute for, learning. A gradual cultural shift towards recognising that collecting and reporting feedback data was necessary, but insufficient, sometimes meant limiting engagement with traditional feedback sources or synthesising information to gain a deeper understanding.

“We agreed with commissioners that [baby-weigh] wouldn’t be a service we’d carry on... a big controversy and lots of postings on Care Opinion... we used that feedback... We put on that we were going to make a change and it was made within the week and those

comments really died down... we've been measuring the number of comments that come up over time, combining it with the ones we get via the SUCE [service user and carer experience] forms, and we've had an exponential drop." [Site C, General manager]

In contrast, site B staff were divided in their efforts to meet feedback collection and reporting demands to ensure data availability, however, learning was not necessarily the only, nor the most important purpose from different perspectives, and data was routinely repurposed. Regular meetings designed to bring efforts together contained limited scope for improvement work, recognised by the newly appointed head of nursing who felt the majority of feedback was supplementing pre-determined decisions or falling into the 'patient feedback abyss'.

"It's like a bolt-on for many people. Day-to-day you're caring for patients. When they come to think about service redesign and improvement we're a long way to go. They sort of make their minds up and think "well we'll go to patient experience and get some data"... We haven't got co-design and co-production here, we have tried it, we have done it in some areas, but I still think it's a bit tokenistic." [Site B, Head of patient experience]

What was perceived as an overwhelming quantity of feedback being received at site A, also meant that collection and resolution of individual patient concerns was all-consuming, leaving no space to report, and to a lesser extent, learn.

"We're not quite at the coal face as the emergency services are, but people do contact us in a similar vein. They're upset, annoyed, anxious, they are ill, some people are grieving. Some people want to raise concerns about the fact they have lost a loved one and they don't understand what has happened and they want answers." [Site A, PALS officer]

Influential individuals

Attitudes towards online feedback, how they translated into improvement work and the culture of teams being oversaw were heavily influenced by key individuals in positions of management. Turnover within such positions had enormous effects on the organisational approach, providing the opportunities and challenges. At site B, retirement of the head of patient experience, and appointment of a new director of nursing appeared to have immediate influences. However, it was too early to understand the longer-term implications and what this meant for engagement with Care Opinion. Similarly at site A, the new appointed chief nurse saw value in their work, which was perceived to have brought valuable opportunities.

"We're going through a lot of changes having a new chief nurse at the top and we just need that to settle... then we will know from her how we need to adapt and what she needs from us in the future." [Site A, Senior patient experience officer]

On the other hand, site C had a large team of staff who had overseen the implementation of Care Opinion from the beginning, which helped to increase momentum in enthusiasm. Longstanding Care Opinion champions, including the head of communications and involvement and experience officer, continued to provide support to staff using Care Opinion across the organisation.

"It's all brought into focus with our anniversary coming up of the 10 years and the things that we have learnt. I suppose what I'd like people to really understand is the true potential of online feedback if it's used intelligently... I just want people to get that lightbulb moment and realise that actually, Care Opinion can help you and reduce your workload if it's used in the right way." [Site C, Involvement and experience officer]

Care Opinion became embedded within various routine Trust processes, including staff induction, opening meetings with patient stories and linking to the platform within email signatures. Additionally, job descriptions were updated to capture responsibility, Care Opinion guidelines were produced, the involvement team were physically located nearby senior staff, involvement champions were embedded within each directorate, and powerful quotes from service users were physically printed on the walls.

"We expect and we encourage feedback. And so the example is set in terms of wanting to respond to it. The fact that we're on Care Opinion shows that we want that feedback and we want to respond to it, it's that whole kind of circle... it's something to do with the culture we encourage. It's not a blame culture, it's a learning culture." [Site C, General manager]

However, it seemed that while some staff at sites A and B had ambition to improve their engagement with Care Opinion, it was more than just an issue of individual staff attitudes, funding, time or resource, but one of the underpinning culture, requiring enthusiastic leadership and teams, collaborative working and passion spreading over time.

Discussion

Implications for patient experience research

Our multi-case analysis compared how online patient feedback was responded to and used in three hospital trusts, highlighting three key themes. Firstly, distinct underlying rationales for patient feedback engagement, as defined by Martin⁶ as the democratic and technocratic rationales, helped determine a range of factors including the extent to which patient feedback was 'humanised', the degree the 'patient experience lag' could be attended to, and the amount of organisational support staff were given. Secondly, multidisciplinary collaboration was a key enabler to overcoming barriers with online patient feedback, including disseminating a sense of feedback ownership, and partnering with similar teams helping to overcome

‘contextual blindness’. Thirdly, there was a risk of online patient feedback falling into an ‘abyss’. This was overcome where action was prioritised over and above collecting and reporting data and influential individuals in senior management disseminated a passion for improvement. In summary, hospital trusts are still not learning from the huge amount of patient feedback that is collected, are delayed in responding to patient’s needs, preferences and technology, and consider online feedback a courageous step into the unknown. These findings align with critique that gathering patient feedback in the absence of improvement can be nothing more than a data collection exercise^{12,13}. However, our findings also suggest that online patient feedback can support extending the boundaries of the ways in which healthcare can be improved in practice, with direct utility for a wide range of stakeholders spanning physical and mental healthcare settings. These findings may require national level support from policymakers and can be translated into five key implications for policy and practice.

Implications for policy and practice

Hospital trusts should engage with a broader collection of patient feedback sources.

Organisations should avoid missing untapped value in patient feedback by being supported to engage with a variety of available mechanisms based on the local needs of their organisation and patient profile, including unsolicited online feedback, such as Care Opinion. Firstly, staff should be made formally aware of the potential sources of patient feedback before they can begin to realise their value, how they can effectively engage and how to harness information to inform improvements. To achieve this, students coming into the caring profession could be trained accordingly, and staff in-post could be provided with protected time to consider feedback from a variety of sources and engage in improvement work based upon it. This may help such activity to become culturally embedded and overcome the prioritisation of “sanctioned” feedback sources,²⁰ freeing up valuable capacity. However, effective engagement may require adaptations to existing, or the development of new, processes and infrastructure, as those designed to suit traditional mechanisms such as surveys and complaints are often not fit for purpose.

Patient feedback should be seen as a collective responsibility.

Online feedback is often thought of as a responsibility of a few individuals from the patient experience office, whereas improvement work is seen as a nursing responsibility, with a lack of doctor representation. However, engaging multidisciplinary staff widely across the organisation has shown to empower local ownership and invoke a routine cycle of learning and improvement within the context of a supportive culture and facilitative infrastructure at site C. This ranged from volunteers, frontline healthcare staff,

centralised teams, service managers, the board and others working in more senior strategic roles. Based on this premise, all healthcare staff, including those working at the blunt and sharp ends of care, and in particular, stakeholders who feedback directly concerns, should be actively involved in hearing, and learning from the information. Assertions from Powell et al.,²⁰ that struggled to pinpoint responsibility for patient experience, and Donetto et al.,¹³ that found the ultimate responsibility for the way information was collected, interpreted, and used was often held within a single discipline, were evidenced here within the context of online feedback specifically. Montgomery et al.,²¹ also supportively suggested that engaging multidisciplinary stakeholders can enhance team ‘capital’. This could be achieved by embedding online feedback into routine Trust processes such as staff induction and meetings which regularly bring multiple disciplines together.

Staff should ensure that patient experience work aligns with the core objectives of listening and bettering patient care.

Organisations should be supported to continually review their patient experience practices ensuring they are using feedback to effectively monitor, assure, and improve the quality and safety of care at a local and/or organisational level, as well as truly listening to patients and valuing their feedback. This could be supported by a training intervention to enhance knowledge that patients offer a ‘scaffold’ or ‘safety net’ that supports the effectiveness of healthcare systems,²² as encouraging staff to invest time and resource into things that they do not see the value in could be counterproductive. This may also require a policy shift in focus from the collection and reporting of patient feedback towards how information is being analysed and in what way learning can be derived. In turn, the rationale and effectiveness of engagement with particular feedback sources may be reflected upon and adapted, such as those which are time and resource-intensive for staff, yet not resulting in improvements. Additionally, staff should be empowered and supported to consider implementing innovation to learn from large volumes of feedback being received, rather than forced to spend their time on the treadmill of resolution for individual patient concerns.

Staff should respond to online patient feedback using a transparent, conversational approach.

Attention needs to be paid to how organisations develop, adapt, and maintain their approach to responding to online patient feedback at a macro level, and interventions could target ineffective approaches where necessary. This may require multidisciplinary staff training, support and empowerment to not only listen to patient feedback, but also to respond in meaningful ways that communicate any action derived,²³ using the identified typology as a valuable training tool¹⁵. Additionally, staff could be supported to

learn from existing examples of excellence internally, locally, or externally where a transparent, conversational approach to responding is already being taken. Resourcing responding activity may help to avoid patients being ignored or responded to generically online and raise meaningful conversations between patients and staff. This engagement may also shift, perpetuate, and maintain an organisational culture in which transparency is embraced.

Online feedback should maintain authenticity, nuance, and humanity as it moves through the healthcare system to facilitate improvement efforts.

In order for narrative patient feedback to drive improvement at a service or organisational level, staff must connect with the human experiences of patients and use such foundations from which to develop meaningful interventions. Therefore, free-text narrative feedback, such as that provided by Care Opinion, should maintain authenticity, nuance, and humanity as it moves through the healthcare system where possible. Supportively, Montgomery et al.²¹ highlighted the importance of not only physical proximity but also empathic proximity to patients' experiences, with staff preferring feedback to be unmediated by bureaucracy.

Putting these recommendations into practice will not be a quick or easy undertaking for organisations, due to the complex barriers highlighted and the time and resource required, as demonstrated by the gradual layering of cultural change at site C over time. Therefore, top-down support from external drivers such as government, policymakers and service providers are required to alleviate pressures. For instance, strategic priorities outlined by the NHS and policy, inspection criteria from the Care Quality Commission (CQC) and commissioning decisions could pay attention to the recommendations outlined and ensure that they are in alignment. Further research is also required to explore the potential saving of vital resources downstream, if these recommendations were put in place, such as a reduction in formal complaints, litigation or escalation in other ways.

Limitations

Some potential areas of interest were not explicitly examined due to being out of scope of the research, such as the wider implications of approaches to online feedback elsewhere in the system. Methodologically, it is also impossible to understand how the phenomena of online feedback acts in all contexts, yet comparisons across and within the case studies may enable assumptions to be made about how they may appear in similar contexts¹⁸. Finally, while authors did all that they could to emphasise confidentiality and make participation as safe as possible, it cannot be determined if recruitment secured participation of a breadth of views or obtained complete accounts from those who consented to be interviewed. The early effects of the COVID-19 global pandemic contributed to this by

cutting fieldwork short. Nevertheless, fieldwork was largely complete and therefore, it was thought to have limited impact. In any ethnography, it is also impossible to gain understandings from every vantage point of an organisation. In attempts to reduce such risks and gain a holistic picture, multiple methods of data collection were used, and opinions were sought from a variety of individuals, including those deemed to be gatekeepers, typical cases, significant cases, and deviant cases.

Conclusions

Our multi-case analysis suggests that there may still be a way to go for some organisations to culturally embrace online patient feedback as a valued means to improve. However, we present five ways in which our findings might inform policy and practice to support its' use and usefulness to inform learning at a service and organisational level.

References

1. Vincent, C. A., & Coulter, A. (2002). Patient safety: what about the patient?. *BMJ Quality & Safety*, 11(1), 76-80.
2. Coulter, A. (2011). *Engaging patients in healthcare*. McGraw-Hill Education (UK).
3. England, N. H. S., & Improvement, N. H. S. (2019). *The NHS patient safety strategy. Safer culture, safer systems, safer patients*.
4. Marsh, C., Peacock, R., Sheard, L., Hughes, L., & Lawton, R. (2019). Patient experience feedback in UK hospitals: What types are available and what are their potential roles in quality improvement (QI)? *Health Expectations*, 22(3), 317-326.
5. Palmer, V. J. (2020). The participatory zeitgeist in health care: it is time for a science of participation. *Journal of Participatory Medicine*, 12(1), e15101.
6. Martin, G. P. (2008). 'Ordinary people only': knowledge, representativeness, and the publics of public participation in healthcare. *Sociology of health & illness*, 30(1), 35-54.
7. Duschinsky, R., & Paddison, C. (2018). "The final arbiter of everything": a genealogy of concern with patient experience in Britain. *Social Theory & Health*, 16(1), 94-110.
8. Francis, R. (2013). *Report of the Mid Staffordshire NHS Foundation trust public inquiry: executive summary (Vol. 947)*. The Stationery Office.
9. Rozenblum, R., Greaves, F., Bates, D. W. (2017). The role of social media around patient experience and engagement. *BMJ Quality & Safety*, 26(10), 845-848
10. Coulter, A., Locock, L., Ziebland, S., Galabrese, J. (2014) Collecting data on patient experience in not enough: they must be used to improve care. *BMJ: British Medical Journal*, 348, 2225.

11. Sheard, L., Peacock, R., Marsh, C., & Lawton, R. (2019). What's the problem with patient experience feedback? A macro and micro understanding, based on findings from a three-site UK qualitative study. *Health Expectations*, 22(1), 46-53.
12. Locock, L., Montgomery, C., Parkin, S., Chisholm, A., Bostock, J., Dopson, S., Martin, A. (2020). How do frontline staff use patient experience data for service improvement? Findings from an ethnographic case study evaluation. *Journal of health services research & policy*.
13. Donetto, S., Desai, A., Zoccatelli, G., (2019) Organisational strategies and practices through which patient experience data can be linked to care improvements in acute NHS hospital trusts: an ethnographic study. *Health Services and Delivery Research* No 7.34. Southampton, UK: NIHR Journals Library.
14. Ramsey, L., Lawton, R., Sheard, L., & O'Hara, J. (2022). Exploring the sociocultural contexts in which healthcare staff respond to and use online patient feedback in practice: In-depth case studies of three NHS Trusts. *Digital Health*, 8, 20552076221129085.
15. Ramsey, L. P., Sheard, L., Lawton, R., O'Hara, J. (2019). How do healthcare staff respond to patient experience feedback online? A typology of responses published on Care Opinion. *Patient experience Journal*, 6(2), 42-50.
16. Tong, A., Sainsbury, P., & Craig, J. (2007). Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *International journal for quality in health care*, 19(6), 349-357.
17. Knoblauch, H. (2005, September). Focused ethnography. In *Forum qualitative sozialforschung/forum: qualitative social research* (Vol. 6, No. 3).
18. Stake, R. E. (2013). *Multiple case study analysis*. Guilford press.
19. Braun, V., & Clarke, V. (2019). Reflecting on reflexive thematic analysis. *Qualitative Research in Sport, Exercise and Health*, 11(4), 589-597.
20. Powell, J., Atherton, H., Williams, V., Mazanderani, F., Dudhwala, F., Woolgar, S., (2019) Using online patient feedback to improve NHS services: the INQUIRE multimethod study. *Health Services Delivery Research*;7(38).
21. Montgomery, C., Parkin, S., Chisholm, A., & Locock, L. (2020). 'Team capital' in quality improvement teams: findings from an ethnographic study of front-line quality improvement in the NHS. *BMJ Open Quality*, 9(2).
22. O'Hara, J. K., Aase, K., Waring, J. (2019) Scaffolding our systems? Patients and families 'reaching in' as a source of healthcare resilience. *BMJ Qual Saf* 28(1): 3-6.
23. Baines, R., Donovan, J., Regan de Bere, S., Archer, J., & Jones, R. (2018). Responding effectively to adult mental health patient feedback in an online environment: A coproduced framework. *Health Expectations*, 21(5), 887-898.