**Valuing feedback: an evaluation of a National Health Service programme to support compassionate care practice through hearing and responding to feedback.**

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**Abstract:**

There is an emergent recognition in healthcare that people need to be at the heart of services and experiences of care matter, these should therefore be recognised and enhance practice.

The aims of this research were to evaluate an NHS development programme; Valuing Feedback. The programme focused on supporting compassionate care practice by enabling NHS staff to listen, learn and respond to feedback enabling the development of practice.

Findings identified that participants had a heightened awareness of the power and importance of feedback to support practice change. An enhanced understanding of using the feedback tools Emotional Touchpoints and Envision Cards was evident and working with these tools during the programme supported local implementation. Participants identified learning and changes to their practice resulting from feedback, specifically development in their own practice and service change. Participants identified that listening to positive and negative feedback based on emotional experience involved being brave. There was a requirement to be open and listen to criticism. Participants highlighted that feedback activities require support, as they need time to plan, undertake, reflect upon and initiate development.

Conclusions from this research highlight the value of feedback focused on emotions and understanding experiences of patients, relatives and staff. Such feedback impacted on practice. Opportunities where NHS staff shared and learned from feed back was highly valued. It is necessary to consider how the activity of feedback can be effectively supported, enabling staff, their teams and organisations to prioritise feedback activity and develop compassionate care practice for patients, relatives and staff.

**Keywords**: compassion, compassionate care, emotional touchpoints, feedback, relationship centred care and photo elicitation.

**Introduction**

Building on an action research programme titled Leadership in Compassionate Care Programme (LCCP), NHS Education for Scotland commissioned Edinburgh Napier University to develop learning materials focused on gathering feedback to support the development of compassionate care practice. This was part of a broader programme of work, including e-learning and funded by NHS Education for Scotland to support implementation of The Patient Rights (Scotland) Act (2011). Emotional Touchpoint packs and Envision cards were developed as tools to gather feedback, and a series of masterclasses (Valuing Feedback Programme) were delivered across NHS Scotland. The aims of the master classes were to explore how to:

* Listen, learn and respond to feedback
* Work with feedback activities Emotional Touchpoints (ET) and Envision Cards in practice
* Enhance compassionate care for patients, relatives and NHS staff

**Introduction and literature review**

Scotland’s Quality Strategy (Scottish Government a, 2010) states that people need to be at the heart of the National Health Service (NHS) and that individuals’ views and perceptions about experiences of care need to be gathered and the findings used to enhance care delivery. The Patient Rights (Scotland) Act (2011) sets out the rights of patients, their families and carers to give feedback, provide comments, raise concerns or to make complaints about the care they receive. The act states that staff should be trained and supported to respond to feedback and complaints efficiently and effectively. Reports from the Scottish Public Services Ombudsman also indicate that people who raise a complaint express a lack of involvement, choice and communication with healthcare professionals. Dissatisfaction is often expressed by complainants about the lack of individualised or person centred care, resulting in a poor experience. The experiences and feedback from staff to inform practice initiatives which contribute to high quality care also need to be taken into consideration (Tresolini, 1994). In order to ensure that NHS staff can respond to comments and concerns as well as compliments, staff need to be well informed, trained and skilled (Scottish Health Council, 2014).

Research findings suggest a discrepancy between patients and healthcare providers perceptions of compassionate care- a phenomena that is replicated across the globe   
(Sinclair et al, 2016).

The challenge for healthcare providers is how to collect feedback from patients, carers and staff that can be used to support quality improvement for those accessing and providing care. Quality improvement has in the past focused on professional views and less on patient considerations of care experience and treatment (Siriwardena and Gillam, 2014). There is a growing perception that the caring dimension in healthcare has been lost within organisational cultures focused on targets, financial constraints, reduction in length of patient stay, increased acuity and technical competence

(Burdett Trust for Nursing 2006; Department of Health 2005; Healthcare Commission 2009; Mid Stafford NHS Foundation Public Inquiry 2013; Patients Association 2009). These targets have become the benchmark by which quality of care is measured; however, from the patient’s perspective, they are not the only measure of quality care. (Mid Stafford NHS Foundation Public Inquiry, 2013; Scottish Government a, 2010).

Compassion is identified as a hallmark of quality care, it is given credence within healthcare systems and recent recommendations state compassion to be a core value of healthcare practitioners (Mid Stafford NHS Foundation Public Inquiry, 2013).

Increasingly it is recognised that compassionate care can be difficult to define; it varies in context and is often viewed as being individual and subjective and therefore can be difficult to articulate and measure (Smith, 2008). Evidence suggests there is a gap between patients’ and practitioners’ perceptions of what constitutes compassionate care and its’ subsequent delivery (Sinclair et al, 2016b). This finding supports a potential for feedback to determine a collective understanding of compassionate care between patients, families and healthcare staff.

The LCCP action research aimed to embed compassionate care in NHS healthcare practice and undergraduate nursing and midwifery education. A key outcome of this action research was the development of a model for compassionate care in practice which incorporates six key components, see Table 1. This model was developed from the analysis of action research data gathered from service users, family carers, students and service providers within healthcare over a five year period. The action research and development of the model is detailed in the final report of the LCCP (Edinburgh Napier University and NHS Lothian, 2012). The six components identify related activities that support compassionate care development in practice. The activities require to be undertaken between care providers, service users and their families / important others; for example the component ‘caring conversations’, should take place between care providers as well as between staff and service users. This involves debating, challenging and celebrating care practices. The LCCP action research identified that having caring conversations is a key activity supporting compassionate care to flourish. This model is undergoing further testing and key indicators, based on the six key components, aimed at supporting practice development are in progress.

**Table 1.** Model for compassionate care in practice (Edinburgh Napier University and NHS Lothian, 2012)

|  |  |
| --- | --- |
| Caring conversations | Discussing, sharing, debating and learning how care is provided amongst staff, patients and relatives. |
| Flexible person centre risk taking | Making and justifying decisions about care, in respect of context and working creatively with patient choice, staff experience and best practice |
| Feedback | Staff, patients and families giving and receiving specific feedback about their experience of care. |
| Knowing me knowing you | Developing mutual relationships and knowing the persons priorities, to enable negotiation in the way things are done. |
| Involving valuing and transparency | Creating an environment throughout the organisation where staff, patients and families actively influence and participate in the way things are done. |
| Creating spaces that work | The need to consider the wider environment and where necessary be flexible and adapt the environment to provide compassionate care. |

Gathering and responding to ‘feedback’, was also identified as a key component activity supporting compassionate care practice. (Edinburgh Napier University and NHS Lothian, 2012). The tools developed for the Valuing Feedback Programme focused on supporting staff to seek feedback using a Relationship Centred Care (RCC) approach and to use this evidence for service improvement. Learning materials supporting two feedback processes were developed; Emotional Touchpoint Packs and Envision Cards.

Emotional Touchpoints (ET): Bate and Roberts (2007) discuss the importance of hearing patients’ experiences to help develop services but there is a challenge in hearing the experience of others (Goodrich and Cornwall, 2008). It can be difficult for patients to openly share their experiences of healthcare, especially if it has been a negative experience due to a fear of compromised care in the future (Coyle and Williams, 2001). However, the value of hearing the experiences of others is considerable as it can help to provide meaning to healthcare practices (Dewar, MacKay, Smith, et al, 2010). ET is a feedback method focused on understanding a situation through the emotions experienced. Individuals are invited to think about key points in their care experience by using emotional words to describe this. This approach to feedback is consistent with relationship centred care. The focus on emotion is seen as crucial to the development of effective and meaningful relationships between patients and professionals (Freshwater and Stickley, 2004).

Bate and Roberts (2007) describe the listener during this process as being able to suspend judgement, listen deeply and respect what is being said. This provides an ability to learn and consider possibilities allowing for opportunities to think about change in a creative and positive way (Dewar et al., 2010). ETs is therefore a method of gathering feedback that can be important and meaningful to support developments in practice. Emotional touchpoint packs were developed with the purpose of providing a resource for this process. The packs include a case, inside which is a training DVD outlining the aims and process of ET and how feedback from this process can be used for service improvement. Cards with emotional words (both positive and negative) and examples of touchpoint cards (for example: talking with doctors) are provided. Written instructions of the ET process are included in the pack.

Envision cards: images can be used in different ways to help people identify and talk about their experiences and feelings. Images may support individuals to communicate in a creative manner and evoke deeper elements of human experience. This process, known as photo elicitation has been used within the context of practice development for many years (Harper, 2002). Envision cards are a pack of postcards containing a range of images such as scenes from nature, symbols, people and objects, for example a set of keys. These cards can be used in a variety of ways to support feedback activity. For example when using with a healthcare patient, the images can be placed on a table and the patient is asked to choose an image that says something to them about the care they have experienced. The patient is then encouraged to describe why they selected this image. In this example this feedback activity can enable a focus on the patients’ priorities and agenda, and legitimises a feedback opportunity based on experience. How this activity is facilitated is critical, patients need to experience a sense of value and worth to comfortably engage in this feedback process.

In summary, amidst the complexity of providing compassionate care within contemporary healthcare practice, it is evident care providers require knowledge, skill and practical tools to engage in gathering feedback and to use this evidence for service improvement.

**Research questions**

1. What was the impact on practice of a programme focused on supporting NHS staff to listen, learn and respond to feedback
2. How did the programme support practice improvement in compassionate care?
3. What were the key components of the programme that supported practice improvement?

**Description of Valuing Feedback (VF) Programme:**

The aims of the programme were that participants would:

* Develop an increased understanding and application of compassionate, safe, relationship centred and effective care
* Develop skills of using feedback processes and Appreciative Inquiry to examine and develop practice
* Work with fellow participants to exchange ideas, build upon expertise in the group and develop practice

Participants were encouraged to be open to ideas, work with possibilities rather than focus on limitations, challenge their own values, beliefs and assumptions. It was expected that facilitators, participants and their managers would work together to develop practice. The programme was participatory and experiential in nature, each master class involved participants working with feedback tools during the class and being encouraged to use them within their work setting. Feedback from experiences of using the tools in practice were incorporated into subsequent masterclasses. The ethos was to draw on both existing and experiential learning of group members enabling application of feedback activity to local practice. The experiential learning undertaken by programme participants involved using the feedback tools with patients, relatives, students and colleagues, who they chose to seek feedback from was dependent upon their work setting and context.

**Valuing Feedback Programme**

Master classes lasting three hours were delivered on three occasions to eight Health Boards in NHS Scotland. The master classes were delivered over a period of up to six months in each NHS Board. To ensure consistency, two facilitators provided the programme within each Health Board. The number of participants within each Health Board are identified in table 2 and table 3 identifies the NHS roles undertaken by participants. Participants were recruited to the VF programme through the following process. An information and invitation letter was sent by NHS Education for Scotland to all NHS Boards, a lead for each NHS Board was asked to liaise with the VF Programme lead to discuss participation and practical arrangements. Following this discussion the lead from participating NHS Boards organised a group of staff to participate in the programme. Participants were therefore selected by their own NHS Board for a variety of local reasons such as developing a team engaged in working with complaints and feedback or directly targeting a team whose main role was administrative.

Each participating NHS Board received resources to support local feedback activity, these included Envision cards and Valuing Feedback packs (materials to conduct Emotional Touchpoint interviews). A brief description of the masterclasses follows.

**Table 2**

NHS Boards, number of participants, programme completion dates.

|  |  |  |
| --- | --- | --- |
| NHS Board | Participants | VF programme Completion date |
| Board 1 | 8 | March 2013 |
| Board 2 | 18 | May 2013 |
| Board 3 | 25 | May 2013 |
| Board 4 | 14 | June 2013 |
| Board 5 | 16 | June 2013 |
| Board 6 | 24 | July 2013 |
| Board 7 | 11 | August 2013 |
| Board 8 | 16 | December 2013 |
| 8 | 132 | Total |

**Table 3**

NHS roles undertaken by participants.

|  |  |  |
| --- | --- | --- |
| Receptionist GP Practice | Health care support worker | Practice education facilitator |
| Audiology Practitioners | Occupational Health | Podiatrist |
| Director of Nursing | Personal Assistant | Director of Operations |
| Medical Records Administration | Feedback and complaints team | Community mental health |
| Nurses | Physiotherapist | Medical Doctor |
| Training and development | Occupational Therapist | Clinical Governance |
| Student nurse |  |  |

Master class 1

The purpose of master class one was to create a safe learning space where an experiential approach to developing practice in feedback would be created. Participants were introduced to working with Envision cards to gather feedback. An ice breaker enabled participants to get to know one another and agree ways of working for the group, with the aim of creating a safe space and a positive experiential learning environment. An overview of the Leadership in Compassionate Care Project (LCCP) was presented including theoretical approaches of Appreciative Inquiry and Relationship Centred Care. The LCCP model of compassionate care and its six key components was presented.

Envision cards were used as a learning activity with each group. Participants were asked to select an image that represented their views about working with feedback in their practice. Each participant shared their image and views within the group. This experience of working with Envision cards was used to trigger a discussion about their potential as a feedback tool within participant’s practice. Group discussion elicited how participants receive feedback in practice and how the cards could enhance this activity, participants were invited to use the cards in practice. An evaluation of this first class involved using the Envision cards enabling participants to gain further experience of their use.

Master class 2

The purpose of master class two was to reflect on and learn from experiences of using envision cards and introduce the process of emotional touchpoints as a feedback activity.

Participants participated in a group discussion sharing their experiences of using Envision cards within their work setting, what worked well, what was challenging and identifying development possibilities. This master class focussed on the feedback activity of Emotional Touch Points (ET), a process used to understand experiences of giving and receiving care. Participants watched a DVD of the ET process, then within the security of the class setting they had an opportunity to try out this process with fellow participants in the group, preparing them for working with this feedback tool in their own work setting. Participants were invited to try out the process of ET and feedback their experiences at masterclass three. Trying out the ET tool involved identifying a person who was agreeable to sharing a feedback experience, working through information and consent processes with them, using the ET toolkit to hear their story, asking the story teller to reflect on their experience of the ET process, recording the story in writing and typing this into a document, then considering how this story could be shared with colleagues and identifying learning from this experience of feedback and ET.

Master class 3

The purpose of master class three was to focus on learning and responding to feedback through experiences of using the ET process. What worked well, challenges experienced and key learning were explored. Learning focused on how they could analyse and use this evidence to enhance practice. Participants were encouraged to consider the use of feedback tools as part of regular practice within their work setting.

**Methodology**

The evaluation of this programme adopted a longitudinal, mixed methods approach consisting of two phases. Phase one took place throughout the delivery of the VF programme (January to December 2013). In phase one participants were invited to respond to evaluation questions during the three sessions conducted in each participating NHS Board. As this programme focussed on the subject of feedback, evaluation responses from participants were incorporated within each of the three programme sessions. This involved sharing feedback about the programme with participants and providing an opportunity for discussing their evaluation and identifying learning. Within this evaluation research, the discussion of feedback also provided an opportunity for participants to sense-check the data.

In the second phase participants were invited to participate in an online survey administered via survey monkey and a semi-structured telephone interview. The purpose of this second and retrospective phase of evaluation was to determine the impact of the programme on participants’ practice over time. What feedback methods had been adopted, if any, and what was the experience of incorporating these methods into practice?

**Data collection methods**

Data were collected in two phases

**Phase One**

Consent to participate in evaluation activities was requested and discussed with each group at the commencement of the first VF master class. This discussion was a component of agreeing ways of working and establishing expectations for both facilitators and participants. This consent process sought permission from participants to include evaluation data gathered over the three masterclasses whilst ensuring anonymity. This data would be published in a programme evaluation report, requested by NHS Education for Scotland and future publications.

The questions adopted in this evaluation followed the theoretical underpinnings of Appreciative Inquiry (Cooperrider, Whitney & Stavros, 2008). The purpose was to understand what worked well, why this was the case and how this can be replicated within different contexts. In exploring what worked well and why, the researchers sought to understand the challenges experienced.

All programme facilitators had been actively involved in the LCCP and were experienced in the feedback methods presented. All had significant experience of practice development within healthcare. Each facilitator had a Postgraduate Certificate in Teaching and Learning in Higher Education.

The Phase One evaluation questions incorporated within the VF programme are detailed in supplementary Appendix 1.

**Phase two**

Ethical approval for phase two of this evaluation was granted by Edinburgh Napier University’s Faculty of Health Life and Social Science Ethics Committee.

Recruitment into phase two evaluation involved NHS Education for Scotland contacting NHS Boards to inform them of the proposed evaluation and seeking permission to make contact with their identified lead for the VF programme. Following NHS Board agreement, participants who had completed the VF programme were contacted by email by their NHS Board lead. This email contained study information and a consent form. Those undertaking a telephone interview were requested to make email contact with the lead researcher; an interview date and time was negotiated. For those undertaking the survey they were directed to the online survey and consent was taken electronically prior to commencing the survey.

This phase of the evaluation was funded by NHS Education for Scotland with the intent of conducting a rapid evaluation. The survey and interview questions were developed in collaboration with key stakeholders. The questions were piloted with the group of facilitators and subsequently adapted.

The survey and interviews were conducted over a period of two months between February and March 2015, they were conducted thirteen months after completion of the Valuing Feedback programme. The VF programme was delivered from January to December 2013; this meant that the period of time from completion of the programme to participation in the phase two evaluation represented a period of twelve to twenty four months.

The interview questions were sent to participants ahead of the interview. Written notes were taken by the interviewer during the telephone discussion. On completion of the interview the discussion was transcribed and reviewed by the participant; this allowed the participant an opportunity to review the interview content for accuracy whilst providing an opportunity for additional comment or reflection. The survey questions and responses are included in Supplementary Appendix 2. The semi structured telephone interview questions are identified in Supplementary Appendix 3.

**Analysis of Data**

The analysis of data adopted a sequential mixed methods approach (Creswell et al., 2003). The mixed method approach involved analysis of findings from each data source then collectively analysing key findings across the data.

***Phase one data analysis.*** Supplementary Appendix 1 identifies the evaluation questions used during phase one. Data were gathered from participants during each VF workshop. The evaluation questions were incorporated into group discussions and directly reflected learning activities. For example, the questions focused on Envision Cards (What are your experiences of using the Envision Cards? What was your learning? What was a challenge?) were used in master class 2 to identify and share learning experiences about this feedback activity.

Four members of the facilitation / research team undertook independent data analysis by reading and rereading the data gathered during phase one. This involved identifying themes which represented important ideas across the range of data gathered. On completion of this independent data analysis, all themes were shared with the facilitation team and a second stage of collaborative analysis took place. This involved comparing and synthesising themes and identifying key representative quotes to illuminate meaning and facilitate understanding of key findings.

***Phase two data analysis***

***Survey data analysis.*** Survey monkey was the questionnaire software used to gather and analyse the survey data. A descriptive statistical analysis was used to describe and summarise the quantitative survey data.

Frequencies were used as a summary measure, identifying the percentage of responses that fell into a set of categories – for example finding the percentage of replies that fell into the five categories of a Likert scale in response to the question;

I have implemented learning from this programme into my work?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Strongly agree | Agree | Disagree | Strongly disagree | Not applicable |

***Telephone interview data analysis.*** The telephone interviews were analysed by the researchers using a thematic analysis approach (Braun & Clark, 2006). This approach involved the research team searching for important moments in the data and identifying initial codes. Following code identification, themes were developed based on commonalities and recurring concepts; this was an inductive process as the emergent themes were driven by the data rather than analysing the data through the lens of an identified model or theory.

The research team undertook a collaborative data analysis of phase one and two of the study, acknowledging the mixed methods approach of the evaluation. This analysis involved reviewing all analysed data - evaluation feedback from the programme, survey findings and qualitative interviews. The team analysed all findings across the data and identified connected concepts and summary findings.

During both phase one and two of data analysis, ensuring data were checked and reviewed by participants themselves, and that the research team undertaking both individual and collaborative data analysis, sought to achieve authenticity and credibility of the research findings.

**Results**

***Phase one***

Eight boards participated in the VF programme, incorporating 132 participants.

**Profile of participants**

During the twenty four masterclasses, 132 participants provided a total of 667 responses to evaluation questions. Due to the volume of data, the focus of evaluation presented in this paper represents participants’ learning and experiences related to feedback and developments in practice rather than the experience of undertaking the programme itself.

Theme: Envision cards: capturing experience and challenging assumptions.

Participants felt excited about opportunities to use the feedback tools. A large number of participants valued the use of the Envision Cards and how they can be used to receive a different form of feedback.

You get rich feedback you wouldn’t get in other ways.

We can make assumptions about what the feedback will be but it can be surprising.

I have useful tools to use now which capture experience.

Participants wanted to learn new skills relevant to their role, which they could share with others, they identified learning related to listening skills and practical aspects of using feedback in practice. The practical approach of trying feedback tools between masterclasses and sharing experiences from practice was identified as valuable and supporting implementation.

Theme: Emotional touchpoints: A conduit and a challenge to change practice.   
Participants identified ‘top tips’ for working with ET; these included being prepared and thinking carefully about consent, ensuring the person knows how the story will be shared. Setting time limits, listening really hard and making time for writing up and identifying key quotes was important. Considering carefully what to do with the story, how to share it and with whom this was particularly pertinent with staff feedback.

How to listen to staff and patients in a more open, non-judgemental format

need to allow people to feel listened to

If honest I am still a bit nervous

It was acknowledged that using these feedback approaches required knowledge, skill and a level of confidence.

I have learned to try and take positive feedback rather than always looking at the negative.

Hearing negative feedback was identified as difficult and some participants highlighted a need to be brave.

***What I can commit to and take forward?***

Participants identified activities where the feedback tools could be used; for example, as part of personal development planning and to provide feedback at monthly staff meeting. Overall there was a heightened awareness of the power and importance of feedback, an enhanced understanding of the feedback tools and consideration of local approaches to implementation.

**Phase two Findings**

***Survey findings***

The survey findings and responses are presented in Supplementary Appendix 2

Thirty four participants completed the survey; this represents 26% of those who undertook the VF Programme. This appears to be a low response rate. This may reflect challenges experienced by researchers recruiting participants from eight NHS Boards across Scotland and locating their whereabouts after a period of 24 months post-completion of the VF programme. It is acknowledged in literature however that on line survey response rates have been declining generally in recent years (Galea & Tracy, 2007).

Those who completed the survey reported predominantly positive responses to questions, particularly questions focused on implementation and impact on practice. For example, in question three (I have implemented learning from this programme into my work), 16 out of 21 participants agreed and two out of 21 disagreed with this statement. In question five (The programme has helped me to be more effective in managing feedback at work), 18 out of 20 participants agreed and one disagreed with this statement. The survey identified a range of potential activities that could support participants to enhance the management of feedback; participants identified planned opportunities to reflect on these issues with colleagues as the most useful strategy. This finding is consistent with the phase one evaluation feedback and phase two telephone interviews. One participant from the survey stated;

[We need to] discuss more openly re complaints and concerns and use feedback to improve practice.

**Telephone interview findings**

Four telephone interviews were conducted, this low response was again a direct result of difficulties experienced reconnecting and recruiting participants from the VF programme. Interviewees focused on the process of using ET interviews as a way of receiving feedback and initiating developments.

Following analysis the following themes were identified from telephone interviews, quotes are included to demonstrate analysis findings.

Theme; The power of feedback centred on emotions.

Participants highlighted that feedback which had an emotional focus had impact, for example highlighting a sense of pride in the team.

My manager went to do the ETs with patients …. This was anxiety-provoking because it was our manager getting feedback about us but it has been really good …. she said that she felt quite emotional when hearing people talk about the good work being done. (P2)

Theme: Importance of hearing positive feedback.

A function of ET is that it provides a structured opportunity for people to consider both positive and negative emotions related to experience. Participants identified that hearing positive feedback had a constructive impact on the emotions and experience of care providers themselves - feeling uplifted and enhancing commitment to the service were highlighted.

I think an important outcome is that the feedback we get from ET is generally very positive indeed. Positive feedback is really important ….. it is easy to forget this and not think it is important but it is really important to give this good feedback back to the clinical areas. (P1)

Theme: Evidence ‘clout’ supporting development

Participants were able to identify direct responses and changes following feedback using an ET interview. One participant identified that this form of patient feedback influenced change and had ‘clout’.

The feedback has been really powerful and has influenced changes on a practical level so when patients said the chairs were too low in the waiting area we were able to use this feedback to get new chairs. Patients told us that it was really difficult to find the service, the hospital has put up new signs to direct patients to the service…… It does seem to be that feedback from patients’ carries more clout. (P2)

Theme: Hearing and responding to feedback is a commitment.

Participants highlighted that completing the full process of Emotional Touchpoints required time and therefore commitment from the practitioner.

I used ET on twelve students, quite a bit of work I would say…… I think time is the key challenge, not just doing the touchpoints but the writing up and ensuring you do the feedback. In my case ensuring the feedback was given to the universities and back to the clinical areas. (P1)

Theme: Colleagues and managers supporting feedback.

Respondents highlighted the positive benefit of sharing experiences and having colleagues to work with to undertake feedback activities. This permitted opportunities for learning and a driver for embedding feedback in practice.

Good to try things out with my colleague or do things on our own and then get together to discuss how things went. My manager has been really supportive and encouraging …. and quickly appreciated the benefits of ETs to gather feedback. (P2)

The practical activities worked well and engaged the group to want to learn more. Discussing examples of using the tools to gather feedback from different perspectives according to each persons’ day-to-day work was interesting. I am ready to have a go and keep practicing now. (P3)

**Limitations of research**

* Evaluation data gathered during phase one may be subject to bias, participants may not have wished to share their views directly with facilitators, particularly as feedback was actively shared during masterclasses.
* Due to the time period between the VF programme and phase two data- gathering, logistical difficulties were experienced recruiting participants, leading to low response rates across study phases.
* The rapid nature and short timescale available for the phase two data-gathering restricted opportunities to recruit participants for interviews.
* In phase one and two data were gathered by members of the facilitation team, which may have produced a response bias, impacting the validity of the findings.
* Participants who completed phase two survey and interviews may represent individuals who were positive toward the programme, introducing a potential sample bias.

**Discussion**

Phase one findings indicated that participants recognised the value of feedback for staff and service improvement. An understanding of and familiarity with using the feedback tools in practice was identified. Sharing and learning amongst participants through the VF programme supported commitment and practical ideas for implementation. A challenge exists for staff in hearing both positive and negative feedback.

Phase two findings: a low response rate for completion of the survey (26%) and interviews (n=4) urges caution in determining conclusions from these findings.

Participants identified that feedback from the ET tool, centred on emotions, provided clout and achieved changes in practice; it also impacted upon staff emotions and morale, e.g. ‘experienced a boost’. The ET process takes time and commitment from staff, particularly seeing the process to completion and determining outcomes in practice. A supportive team and manager can enable the ET processes to flourish.

Considering analysis of the mixed methods data gathered in this evaluation, for those small number of participants who provided longitudinal data, there was evidence of sustaining the use of ET; despite the commitment and work required, this emotion- focused feedback impacted on staff morale and triggered outcomes in practice. In terms of supporting compassion in practice ET appears to have potential in that feedback can be powerful and touch hearts and minds, which have been identified as essential mediums for enhancing compassionate practice (Sinclair et al., 2016b), although there are many others that would help substantiate this important claim. What was identified as supporting this feedback activity to flourish was support from colleagues and managers. When considering evidence of poor practice and an identified lack of compassion (Mid Stafford NHS Foundation Public Inquiry, 2013) feedback processes such as this could act as a flag providing a powerful opportunity for the voice of patients, relatives and staff to be heard within a team and organisation. A survey comment emphasises the link between feedback and the provision of compassionate care.

I believe that using the tools has gathered richer information to take a deeper approach to quality assurance and customer service. I feel we hear more feedback and it is what matters to the person as opposed what matters to the service provider.

**Conclusion**

Conclusions from this research highlight the value of feedback focused on emotions and the benefit of understanding experiences of patients, relatives and staff. Such feedback impacted on practice. Opportunities where NHS staff shared and learned from feedback experiences were highly valued. It is necessary to consider how this activity can be effectively supported, enabling staff, their teams and organisations to prioritise feedback activity and develop compassionate care practice for patients, relatives and their staff. Further research, involving greater numbers of participants including patient participants, and in-depth analysis of data is required to further evaluate these feedback processes and their use and impact on practice over time.

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| --- |
| **Key points for policy, practice and/or research** |
| * The processes of Emotional Touchpoints and Envision cards provided service feedback enabling learning and practice change. |
| * Feedback focused on emotional experiences of patients, relatives and staff provided powerful learning and understanding of varying perspectives supporting the provision of compassionate care. |
| * Feedback processes take time and motivation; staff identified a need to be brave to hear positive and negative feedback, therefore they require local and organisational support to flourish. |
| * Feedback activities had an impact and were viewed as successful when staff had an opportunity to learn, share and reflect together on their local use and application. Further policy acknowledging this complexity and supporting such feedback activities would prioritise and facilitate development. |

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**Supplementary material**

Supplementary material for this paper can be found at the journal website: http://journals.sagepub.com/home/jrn.

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