The qualities of data: how nurses and their managers act on patient feedback in an English hospital

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Abstract

Purpose

To investigate ethnographically how patient experience data, as a named category in healthcare organisations, is actively 'made' through the co-creative interactions of data, people, and meanings in English hospitals.

Design

We draw on fieldnotes, interview recordings and transcripts produced from 13 months (2016-2017) of ethnographic research on patient experience data work at five acute English NHS hospitals, including observation, chats, semi-structured interviews, documentary analysis. Research sites were selected based on performance in a national Adult Inpatient Survey, location, size, willingness to participate and research burden. Using an analytical approach inspired by Actor-Network Theory, we examine how data acquired meanings and were made to act by clinical and administrative staff during a type of meeting called a 'learning session' at one of the hospital study-sites.

Findings

We found that processes of systematisation in healthcare organisations to act on patient feedback to improve to the quality of care, and involving frontline healthcare staff and their senior managers, produced shifting understandings of what counts as 'data' and how to make changes in response to it. Their interactions produced multiple definitions of 'experience', 'data' and 'improvement' which came to co-exist in the same systematised encounter.

Originality

The article's distinctive contribution is to analyse how patient experience data gains particular attributes. It suggests that healthcare organisations and researchers should

recognise that acting on data in standardised ways will constantly create new definitions and possibilities of such data, escaping organisational and scholarly attempts at mastery.

Keywords: patient experience data, quality improvement, hospital, actor-network theory

Since the turn of the century, healthcare organisations and systems have become increasingly interested in understanding how patients themselves experience the care they receive (see e.g. (Berger et al., 2020; Jenkinson et al., 2002; Kenagy et al., 1999; Robert and Cornwell, 2013; Tefera et al., 2016; Ziebland et al., 2013). In England, for instance, such increased importance has been ascribed to the rise of the service user movement, a policy focus on patient choice, increasing clinical emphasis on shared decision-making and self-management and governance mechanisms emphasising public legitimacy and transparency (Duschinsky and Paddison, 2018). Organisations now solicit and collect a huge array of patient feedback or patient experience data. These include national surveys of patients organised by condition or type of service used (e.g. England's annual Cancer Patient Experience Survey), local, hospital-designed surveys, videos of patient stories, and online platforms (Donetto et al., 2019; Locock et al., 2020; Powell et al., 2019). The growing emphasis on the need to track and measure patient experience has been linked to quality improvement strategies, performance management within organisations, and benchmarking between health providers (Gleeson et al., 2016; LaVela and Gallan, 2014). Concepts such as 'accountability, scrutiny, measurement, incentives and markets' (Berwick, 2016) have come to dominate the discourse, giving rise to a landscape of 'rewards, punishments and pay for performance' (ibid).

The development of 'patient experience', 'patient experience data' and 'patient feedback' as categories in the English National Health Service (NHS) has resulted in new infrastructures to collect and mobilise the data for internal and external reporting and for planning improvements in care. NHS hospitals now have entities such as a 'patient experience team', a 'patient experience strategy' and a 'patient experience committee' (Locock et al., 2020; Powell et al., 2019). Alongside the proliferation of the types and quantities of patient experience data and organisational infrastructures, there has been a parallel growth in interest among healthcare academics suggesting that the data or feedback is not being adequately used to drive improvements in care (Coulter et al., 2014). Much of this work has focused on identifying operational fixes such as improving staff training in the collection or use of patient experience feedbacks or different organisational processes to analyse or act on data (Flott et al., 2017; Gleeson et al., 2016; Sheard et al., 2017) .

However, much less attention has been given to data itself and in this article, we shift the analytical focus in this direction. Taking a distinctly anthropological approach to data (see Boellstorff et al., 2015) inflected by sociomaterial perspectives (see e.g. Donetto et al., 2021),

we look closely at the traceable relations of which data is a part and from which it emerges in organisations. In the first section, we look at recent studies of patient experience data, focusing on those that have questioned the stability of data in these contexts. We then present an account of how patient experience data work is conducted in an English NHS hospital we call Sanditon, and in which we carried out fieldwork over the course of a year (2016-17). Specifically, we examine how various understandings of data emerged during an instance of a regular type of hospital meeting called a learning session'. Held every six months, Sanditon's learning sessions drew together nurse managers, senior members of the hospital's 'Quality Improvement' team, and frontline nursing and other staff to discuss how patient experience data had been used to drive improvements in care. We argue that an ethnographic approach attentive to the co-creative entanglements of data and people reveals the shifting and contested meanings of 'data' that are produced in a single, formal and highly systematised encounter. That data seems multiple even in this sort of setting has important implications not only for how scholars write about 'patient feedback' (as if it were a fixed, unitary and abstracted category) but also for how healthcare organisations might properly acknowledge this multiplicity in attempting to improve the quality of care.

Data in relations

Studies have highlighted that, despite the vast quantity of data that is collected about patients' experiences, it is not clear whether and how hospitals and other care organizations use this data to identify and implement improvements in healthcare quality (DeCourcy et al., 2012; Locock et al., 2020; Ziebland et al., 2013). Some studies have pointed out the lack of skills or time among the healthcare workforce for the analysis and deployment of data (Flott et al., 2017). Others have argued for a closer link between patient experience data and formal Quality Improvement methodologies (Gleeson et al., 2016). Among others, Coulter et al (2014) draw attention to the lack of political will in creating a national system for drawing together and comparing the many types of data collected, leading to gaps in knowledge; such a system, its advocates argue, would lead to a more effective use of patient experience data enabling improvements to take place.

However, much of this work does not question the ontological reality of data itself. Rather they assume that if only organisational processes for collecting and acting on data were improved through technical intervention, quality improvement in patient care would be likely to follow; that better data (and better ways of learning from it) will lead to better care (cf.

(Sheard et al., 2017). In a paper examining the reasons why NHS trusts find it difficult to use patient experience data effectively, for instance, Flott et al state that 'the theoretical foundations for why patient-reported feedback should be used is logical' (2016: 2)

Recent interventions have begun to question the idea that data collection in the NHS is 'logical' or leads to stable and predictable outcomes. Pflueger's work on accounting for quality in the NHS, for instance, has examined how processes of data collection and analysis in hospitals creates its own objects - 'quality' and 'patients' - that look far removed from real quality and real patients (Pflueger, 2016, 2015) . The consequences of this are profound: a relentless focus on quality displaces control within organisations. In Pflueger's analysis, a managerial commitment to the assumption 'that quality can be adequately and fully captured by numbers, and then managed through mechanisms of rationalized control' (2015: 185) is seen as having the effect of creating zones of ignorance within an organisation where poor quality - unseen as 'quality' by data - escapes notice. According to Pflueger, data and the processes associated with its collection therefore have the power to reorient a hospital Trust's field of vision, setting misleading priorities and providing false reassurance; accounting for quality 'does not just find things out, but makes them up' (ibid: 181). Pflueger's work is part of a broader move offering critical perspectives on quantification, metrics, evidence and accountability in areas of society such as higher education, law and international development (Merry, 2016; Strathern, 2000) as well as in healthcare organisations (e.g. Moreira, 2012). In their discussion of metrics and organisational knowing, Martin et al highlight what they see as a tension between two competing desires in healthcare organisations: one, a desire to access the multi-vocal richness of data about care received or obtained from patients or carers in unsolicited, unstructured or unsystematised ways, what they call 'soft data'; and two, the possibly constraining managerial use of such data in processes to improve the quality of care (Martin et al., 2015).

Scholarship has also begun to look more closely at the relational aspects of patient experience data in healthcare organisations (Desai et al., 2017; Donetto et al., 2021, 2019; Montgomery et al., 2020; Ziewitz, 2017). For instance, Donetto et al 2019 and Montgomery et al 2020 have both emphasised the relational ways in which frontline healthcare staff understand patient experience, receive patient feedback and act on it to improve care and how certain qualities pertain to data. They explore the kinds of improvement activities that patient-facing nursing and other staff undertake in response to patient experience that is not part of a formal

hospital-authorised data collection or improvement process. It often involves learning about patient experience by, as one matron said, 'keeping an ear out' for issues and 'nipping them in the bud' as they arise (Donetto et al., 2019): 62). For Montgomery et al (2020) this is an effect of the fact that for frontline hospital ward staff patient experience (and the actions taken in response to learning about it) are embodied, intuitive affects. In their analysis, such 'wild data' are produced through everyday actions and are distinct from organisationally mandated formal processes producing 'disembodied' patient experience (what they call 'tamed data'). They argue that this distinction needs to be acknowledged both by staff themselves and hospital managers so that 'patient experience' can be understood more broadly by healthcare providers. Like Pflueger, Donetto et al (2019) and Montgomery (2020) question the notion that patient experience data is a stable, unitary, undifferentiated object that has, by its very existence, the capacity to be acted upon. Rather, in their view, data emerges and is ascribed qualities depend on the types of interactions in which they are involved.

In this paper, we draw on this relational perspective on data but take a more expansive approach to the types of relationships data entertains with various actors across all levels of hospital organizations. While the focus of Montgomery et al's (2020) work is on how patient experience is an embodied resource for frontline staff alone, we think it is crucial to examine situations – such as the learning session we present below – in which different types of staff in a hospital work together with patient experience data in a formal, collective interaction. This allows for an exploration of how different understandings of patient experience - and how to make changes in response to it - rub against each other, producing multiple definitions of 'experience', 'data' and 'improvement' through relations in a particular encounter. This approach is inseparable from the ethnographic method with which we engage. It involves not only sustained observation but also the sustained writing of an account, of staying with the description (what Latour has called 'go[ing] on with the description' (Latour, 2007). Below we present our data gathering methods and discuss our framework for data analysis which draws on ideas developed through Actor-Network Theory (ANT).

Methods
This article is based on fieldwork conducted as part of an ethnographic study looking at how patient experience data was used (or not used) to drive improvements in the quality of care in acute English NHS hospitals, including Sanditon (Donetto et al., 2019). We immersed

ourselves in the worlds of patient feedback at five different hospital organisations, referred to as 'Trusts' in English healthcare parlance. Amit Desai, Giulia Zoccatelli and Sara Donetto carried out 116.5 days of ethnographic fieldwork (interviews, observations and document collection) over a 13-month period (2016-17) across the five fieldsites and conducted individual semi-structured interviews with 65 participants (53 hospital staff and 12 patients) [1]. Trusts were selected on the basis of several factors including performance in the English health inspectorate's national Adult Inpatient Survey, location, size, willingness to participate and research burden. Sanditon was approached as a potentially attractive fieldsite because of its nationally well-regarded approach to patient experience data and quality improvement and its nursing service assessment and accreditation framework (of which the learning session mechanism was a part).

At each of the five Trusts, we observed the work of members of patient experience teams (where these teams existed) and senior hospital staff such as heads of patient experience or directors of nursing who were organisationally responsible for patient experience. We spent time in patient experience offices, observing how feedback was collected, organised, processed, analysed and communicated, sitting and chatting with staff as they wrote internal and external reports, collated tables and composed replies to patient comments. We also regularly followed these staff and others to patient experience committee meetings, quality committee meetings, hospital board meetings, governors' meetings on patient experience, and meetings relating to patient complaints, as well as other types of meeting at which patient experience data was discussed, including learning sessions (of which we observed three), and which are the particular focus of this article. We observed hospital-wide nursing meetings such as monthly Matrons' Forums and accompanied governors and hospital directors and other senior staff on 'walkarounds' and observed ward assessment processes. In addition to hospital-wide work on patient experience, we looked at how patient feedback was collected and used by two particular services within each hospital - cancer care and dementia care - and observed relevant activities and meetings (e.g. cancer Clinical Nurse Specialist team meetings, clinical governance meetings), and spoke extensively and repeatedly with clinical and other staff in these areas, and on wards and clinics, about patient experience, feedback and data, and quality improvement processes. We attended hospital-facilitated meetings of patients, carers or former patients at which experiences were shared with staff by patient; we also conducted semi-structured interviews with patients, carers and former patients about their experiences of providing feedback.

[Authors 1, 2 and 3] took handwritten notes during observations and informal interviews, which were then typed or written up into more complete field notes very soon after. We also requested and read documents including meeting minutes and agendas, reports and strategies produced by our interlocutors, and templates, forms and other material used to collect and report on patient feedback. Formal individual semi-structured interviews were audio-recorded and professionally transcribed. We also took photographs to document aspects of patient experience data work.

Data analysis was iterative. We re-read notes and transcripts, producing short papers, and informal and formal presentations to be discussed in study team meetings, during and after the fieldwork period. These papers or presentations contained commentaries on our emerging data and proposed emerging themes for further exploration. Regular weekly meetings among fieldwork researchers (Authors 1, 2 and 3) allowed for comparison between the different hospitals and testing of emerging themes. Five day-long meetings of the whole research team were also held to discuss emerging themes and potentially useful analytical approaches.

ANT: a flattened, oligoptic perspective on organisational relations

Our thinking in this research has been informed by Actor-Network Theory (ANT), developed by Bruno Latour, Michel Callon and John Law during the 1980s. ANT has been influential in studies of healthcare and healthcare organisations as part of a broader turn to sociomateriality in sociology and social anthropology (Allen, 2014; Barad, 2003; Mol, 2003; Timmermans and Berg, 1997). Although it carries 'theory' in its name, ANT might be better described as a family of approaches and methods to understand the social. ANT provides a basis on which to pay attention to the 'materiality' of organisational activity and the inseparability of the technical and the social in organisational practices (Orlikowski, 2010; Orlikowski and Scott, 2008). At the heart of ANT thinking is the idea that everything in the world is the outcome of interactions between two or more entities (Law and Hassard, 1999), and that these relations produce effects, which we can study. Three consequences flow from this: first, that the qualities of entities in the world emerge through particular interactions, and are not inherent in those entities; secondly, that these interactions – and the qualities that emerge - can (and must be) properly described (Latour, 2007); and thirdly, that as social scientists we approach the worlds we study as 'flat', refraining from *a priori* assumptions about the power, status,

size, nature and scale of actors and instead seeing how these qualities emerge through interactions and relations (Latour, 2007). What does this mean when applied to thinking and writing about how patient experience data works in hospital organisations?

Exploring the enactment of data means moving beyond analyses that see patient experience data as inert, stable entities, open to technical manipulation and refinement, and of seeing 'patient feedback' as an undifferentiated category. By describing and analysing these interactions, we can better understand how relations around patient experience data are continuously produced and to what effect and for whom. Paying attention to the enactment of patient experience data (and looking at qualities emerging in interactions rather than specific identities) and taking a 'flattened' perspective has the corollary of providing alternative visions of hospital organisation.

Our approach here is to treat patient experience learning sessions at Sanditon hospital (and one learning session in particular) as an instance of what Latour has termed oligopticon (Latour, 2007). Oligoptica are sites at which 'sturdy but extremely narrow views of the (connected) whole are made possible…' (Latour, 2007). An oligopticon does not itself allow a view of this whole and not all aspects of a phenomenon are fully revealed. But unlike Bentham's Panopticon from which the whole could theoretically be seen (but no one part seen well), an oligopticon 'is capable of gaining very fine-grained views but only of specific things' (Harvey et al., 2016); this is true both for those entities brought together and enacted through the learning session and for the ethnographer attempting to understanding the relations being performed. By offering a detailed presentation of this oligopticon and of how what is called patient experience data is used in actual observable interactions involving people and data (and which have as their aim to improve the quality of care), we explore here how patient experience and improvement come to be defined and for whom those definitions matter. We argue that neatly mapping qualities of data onto corresponding categories of staff (e.g. 'wild' or 'informal' data = frontline nurses; 'disembodied', 'formal' data = managers) (Martin et al., 2015; Montgomery et al., 2020) underplays the ways in which, for instance, frontline staff achieve valued aims in being part of systemised, formal processes of acting on patient feedback to drive quality improvement. Our approach instead suggests that the study of improvement processes in healthcare organisation should pay attention not to whether the supposedly fixed qualities of feedback or data as 'wild' or 'formal' are inextricably associated with specific staff groups – to do so would once again treat data as immutable and

fixed - but rather to the response by different types of staff to those qualities as they emerge through forms of organisational systematisation. One such form of systematisation is the Sanditon patient experience learning session.

Learning sessions at Sanditon Hosptial

Learning sessions at Sanditon Hospital were a type of meeting at which staff discussed the work they had done to improve patient experience and planned how they would act to improve the quality of care in the future. They were sites at which different understandings and definitions of patient experience, improvement and data emerged. As we suggested above, describing the set of interactions through which this process happens is key to exploring how data are enmeshed in relations, come to have effects and structure relations among different staff in an organisation. Amit Desai attended three learning sessions while doing ethnographic fieldwork at Sanditon Hospital. While each learning session as an event is distinct and only emerges as such through the relations that happen in it, Amit Desai observed common aspects across them (and aspects of other learning sessions are explored further in (Donetto et al., 2019). We focus in this account on the progress of one session held in July 2017 which involved the hospital's community health service teams.

Making patient experience data

Learning sessions brought together people from across Sanditon. Individual service teams in the hospital were required to attend a learning session once every six months. Several service teams (8-10 teams) attended a given session, which were organised by division or subdivision (e.g. surgery, community health etc.) and each meeting lasted up to three hours. Participants included staff nurses, ward clerks, matrons, healthcare assistants, speech therapists, physiotherapists, or housekeeping staff. Services typically sent one or two members of staff to represent them, meaning that there were between 10 and 20 people from various service teams at a learning session.

Learning sessions were organised by Sanditon's Patient Experience Steering Committee which brought together senior nurses and members of the quality improvement team to oversee patient experience-related work in the Trust. The Committee planned the schedule of learning sessions, and tracked the development and outcomes of initiatives to improve patient experience in response to feedback. It was chaired by a corporate nurse we call Juliette, who

was also in charge of managing an authoritative nursing service assessment scheme of the Trust's inpatient, outpatient and community service areas. The nursing service assessment process (of which participation in the learning session was an integral part) was highly valued by frontline staff: nurses and others demonstrated immense pride in being awarded the highest level (and liked the additional autonomy and status within the hospital it brought); they were dejected when assessment panels found them wanting. Learning sessions were also chaired by Juliette but, in her absence, the chairing role was taking by Sarah, a corporate matron who oversaw the assessment scheme in community services. Sarah chaired the learning session we describe in detail here.

Held in one of the many seminar rooms in the hospital's education building, that day's learning session was attended by frontline staff from eight service teams: five community nursing teams (named here A to E), Speech and Language Therapy (SALT), Audiology, and Dietetics. Other non-clinical hospital staff in managerial roles also usually attended Sanditon's learning sessions and were present that day: Kristina, the hospital's Quality Improvement Manager and Maggie, the Service User Experience Director. On this occasion, (and exceptionally), the hospital's Equality and Diversity director, Veronica, was also present. Veronica was relatively new in post and had asked to attend as an observer, to understand better how patient experience and improvement work was conducted at the hospital. In total, 15 people attended that day's meeting.

As in other learning sessions, the meeting opened with a brief presentation by Kristina, the Quality Improvement Manager, who explained the theoretical rationale behind Sanditon's learning sessions. Drawing on basic 'Quality Improvement' (QI) concepts in healthcare (Batalden and Davidoff, 2007), Kristina explicitly linked Sanditon's patient experience work to classic QI processes such as the Plan-Do-Study-Act (PDSA) cycle, authorised by influential organisations such as the Institute of Healthcare Improvement (IHI) (http://www.ihi.org/resources/Pages/HowtoImprove/default.aspx). PDSA, she explained, was based on the enactment of so called 'tests of change', which allowed teams to identify an aim towards which to work; introduce changes to achieve that aim; and to measure whether those changes were leading to actual improvement. Kristina's presentation at the start of each learning session thus placed it within a specific landscape shared by Sanditon's managers, which embedded patient experience data within the hospital's 'Quality Improvement' processes. However, through the presentation of their work, and the discussion it prompted,

participating frontline staff created other practices of patient feedback and improvement that came to co-exist in this encounter. We look in turn at how these practices came to be defined and what associations with other practices they were permitted or denied, and by whom.

'Feedback in its purest form'

At learning sessions (including this one), frontline staff were asked to present three areas of work identified by patient feedback they received over the past six months and report to the session how they had acted on it to improve care; they were also asked to reflect on future improvement work in those areas. This was structured in the learning session by using 'storyboards' (see Fig 1). One after another, teams were called on to present their 'storyboard' to other participants. A storyboard was a PowerPoint slide which each team had produced and circulated to the Chair in advance. The storyboard consisted of two columns: 'patient feedback' in the first column; 'tests of change' in the second column. 'Patient feedback' could be selected from any source, including national feedback instruments such as the 'Friends and Family Test', local patient experience surveys, and 'informally' communicated feedback. As Kristina emphasized in her presentation at the start of the meeting, there were no prescriptions as to the source of patient feedback they selected to work on. The key quality of such feedback, from her perspective, however, was that it was 'looked at over time'.

[INSERT FIGURE 1 HERE]

The first team to present their storyboard in July 2017's learning session was 'Community nursing team A'. They chose to use individual pieces of feedback for each of their storyboard items. The first item referred to feedback from a patient who could not access his medication because the repeat prescription service did not take account of pharmaceutical stock levels. The second item reported feedback from a patient who had had a poor experience removing sutures; the community nursing team asked the Tissue Viability to investigate the suture kits and nursing suture practices. The third item was about feedback regarding the care of a patient with a pressure ulcer and how the nursing team had not taken action to address it. The storyboard was presented by a frontline nurse, who outlined the ways in which each of these pieces of feedback had led to investigations by the community nursing team and produced changes which had improved the quality of care. For the first item, the nurses devised a

system whereby repeat medication would be ordered before the depletion of stock. For the second item of feedback, the suture kit was found to be sub-standard and the nursing team had stopped using it; they reported that patients were much happier and that the sutures were being removed more quickly too. For the third piece of feedback, the nurse reported that they had now initiated a weekly safety huddle action tracker so that staff could be allocated specific tasks.

After this first presentation, Kristina, Maggie and Veronica – the non-clinical 'managers' present - commented on Community Nursing Team A's storyboard. They summarised the actions through additional concepts not relied on directly by the nurses. They focused particularly on Community Nursing Team A's selection of individual, one-off patient feedback. This contradicted the emphasis placed on collecting 'data over time' that members of the quality improvement team had previously told us guided improvement work and that staff were meant to rely on and report at these sessions; it also contradicted Kristina's own QI presentation at the start of the session.

Kristina noted that all the examples presented by the Community Nursing Team A's nurses came 'directly from particular patients' and that this was 'feedback in its purest form'. The purity of this unmediated feedback was used by Kristina as the basis from which other associations could arise. In her discussion, Kristina sought to translate the feedback included in the team's storyboard into something broader than that specific piece of feedback, by highlighting its relationship with concepts which had a wider currency in the hospital world. Thus, for Kristina, the story about patient feedback regarding suture kits demonstrated the 'power of escalation' (i.e. that the team took the issue to an appropriate 'supervising' department). Maggie, the Service User Experience Director, also tried to broaden the scope of this same individual piece of feedback, by noting how the actions taken by Community Nursing Team A demonstrated 'empowerment' on the part of nursing staff to effect improvement in response to feedback. Veronica, the Equalities manager, also commented on seemingly idiosyncratic feedback: 'you can be sure if one person is saying it, then we can guarantee that X numbers of people aren't saying it [though they ought to be]'. This statement had the effect of making the one-off feedback (and the improvement action taken as a result) into something more general, in a similar way to the other comments which linked the feedback to concepts such as 'power of escalation' or 'empowerment'. For Kristina,

Maggie and Veronica, such reinterpretations made the one-off feedback more effective than simply being expressed in its 'purest form'.

The 'feedback' - as transformed through associations with these concepts - was also better able to become part of other reporting mechanisms within the hospital organisation. For instance, Veronica additionally told the learning session participants that:

'Each of these [items] has an equality and inclusion focus. It's much bigger than the individual patient. These sorts of things can have a bigger impact on the [hospital]. You might not realise that what you're doing is 'equality and inclusion' and you might wonder if you were asked "what are you doing about X?" Well, these are your examples!'

She added that 'all of this is going in my report'; by this, Veronica meant that she would be reporting these as examples of ways in which frontline staff addressed equality and diversity issues in responding to patient feedback. This gave the patient feedback a life beyond the learning session and beyond the self-reported actions of the service team.

By creating associations between 'one-off feedback' and concepts such as 'empowerment', 'escalation' and 'equality and diversity', Kristina, Maggie and Veronica made the idiosyncratic pieces of feedback presented in the Team's storyboard fit the formal interpretation of valuable patient experience data (e.g. 'data over time') in Sanditon. This view appeared removed from that of the presenting nurse from Community Nursing Team A, who did not suggest the associations herself, nor offered any comment when the managerial team spoke about 'empowerment', 'escalation' and 'equality and diversity' in response to her presentation. These associations were being made - and made to matter - solely by the managerial team.

Flexing the data

The next storyboard presentation at the learning session, given by Community Nursing Team B, illustrated conversely, that the ability to generalise the meaning of a feedback beyond the specific episode or experience of the patient who left it (and for this generalisation to be authorised) was open to learning session facilitators but not necessarily to service team participants. In her presentation of Team B's storyboard, the community nurse proposed a unified theme characterising the improvement action taken in response to patient feedback. The first patient experience chosen was about a patient with a fungating surgical

breast wound who wanted the same nurse to visit her every time for reasons of privacy; she was uncomfortable with strangers in her home. The presenting community nurse explained that they had 'flexed' their work schedules and rearranged their team to accommodate the patient's wishes. It emerged that they had similarly 'flexed' in response to the two other items of individual patient feedback they had received. Maggie commented that she appreciated that the nursing team had treated each patient's needs individually. Kristina, however, while endorsing this sentiment wanted to push the presenting nurse to consider how the team could go beyond the 'case-by-case' approach: 'can you use this to adapt your service as a whole?' she asked. The presenting nurse seemed confused by the question and replied, 'we're changing the team's mindset about how they can be flexible'.

Through her presentation, the nurse had emphasised the notion of 'flexing' in response to each of the three individual pieces of feedback; from her perspective, this was the quality improvement she and her colleagues had made. For her, that the three items were associated together by the general concept of 'flexing' made them less 'individual' in the way they were being characterised by Maggie and Kristina. In contrast to the previous example above, it was the presenting nurse here who supplied the generalising concept – 'flexing' - which altered the presumed individuality of the pieces of feedback or the resulting improvement. However, as was clear from their questioning, this concept seemed inadequate for the facilitators, or they left it unrecognised. For Kristina, 'flexing' could not be an 'improvement' because the individuality of each piece of feedback (as presented on the storyboard) seemed to persist.

In the instances above, the facilitators on one hand, and the presenting staff on the other, tried to make, refused to make, or refused to recognise associations that transformed individual feedback into something that could be recognised as 'data' or 'improvement'. As this example shows, patient feedback itself – which might otherwise be assumed to be inert or stable – was capable of being put into relations and be shaped by them.

The difference different data makes

We have explored how patient feedback is presented and transformed in the interaction of the learning session. Feedback was associated with concepts such as 'empowerment' which enabled feedback and improvement to be deployed in interactions outside of the learning session. Other sorts of transformation were also present. Information provided by patients about their care could also be transformed for some staff into the named category of 'patient

feedback' by its participation in the learning session. This happened in the case of Community Nursing Team D's storyboard.

In their presentation, the Team D reported on how they had learnt from patients' relatives about the adverse consequences of a recent change which had been made to patient care provision. During their home visits to patients (many of whom had a form of dementia or cognitive impairment), Team D had stopped using paper records and instead recorded information about the visit on an Electronic Patient Record. Patients' relatives felt that this change meant that communication with the team had deteriorated. To address this, the team started using paper communication sheets left at the patients' homes on which relatives and nurses could ask one another questions. Kristina solicited more information. She asked the presenting nurse about the source of the feedback which had led to this change. The nurse explained that her team hosts an electronic message board which allows patients and their relatives to communicate with one another and seek advice. The nurse told the learning session that after the team moved away from paper notes to EPRs, 'our message boards exploded'. From the messages posted online, it became clear that relatives now had no way of knowing whether a nurse had visited their home in their absence because, unlike the paper notes which were left in patients' homes, the EPRs were not shared with them. Moreover, as many of the patients had cognitive impairment, they could not necessarily remember if they had been visited by a nurse or the nature of the discussions.

Sarah found the use of message boards intriguing: 'I wouldn't have thought that a message board would be a source of patient feedback', she told the presenter. Maggie was also struck by the novelty and commented, 'we should recognise different ways of collecting patient experience data. We should acknowledge that different systems work differently. Message boards obviously work for you. You're using the system in a different way.' The recognition by the learning session facilitators that the signals from the message board could act as patient feedback is interesting. The nursing team presented this unproblematically as feedback, a point which was affirmed by the facilitators. But there was not complete agreement. From the nurses' point of view, its status as such was not in question, which is why they brought it to the learning session and included it as one of their three items in the storyboard under the heading 'Patient Feedback'. For Sarah, Maggie and Kristina, however, it was only through the information's involvement in the learning session and its association with an improvement to the service provided by the nurses, that the messages became 'patient

feedback'; this is what explains their surprise and their explanation that 'there are different types of feedback'. The objective fact of patients and their families providing information about their care was not automatically 'patient feedback' for some categories of hospital people. The difference in perspective, revealed and sustained by the learning session asks us to consider: whose definitions of 'patient experience data' and 'improvement' matter?

Discussion

The recognition that the learning session was problematic in the way it set up a particular relationship (and therefore definition) between 'patient experience data' and 'improvement' posed a dilemma only for the facilitators, of which Kristina, the QI manager, was the exemplar. For them, the key issues seemed to be the translation of feedback and action into categories such as 'empowerment' that were meaningful beyond both the frontline healthcare workers' efforts at improvement and the learning session itself. For the frontline staff who presented their storyboards, the learning session was doing something very different. For them, it was not a way in which to define the possibilities of 'data' or 'improvement', despite their actions having these undoubted effects; they did not engage with the facilitators' priorities nor attempt to reshape their presentations according to them. Rather, as we learned through the course of our fieldwork at Sanditon, learning sessions were an opportunity to gain visibility for their successful work to improve care in response to patient feedback, share learning with colleagues and to fulfil performance management tasks in relation to participating effectively in the hospital's nursing service assessment scheme.

We have shown that systematisation in organisations produces multiple practices of 'data' or 'improvement', even in the same encounter. Importantly, the facilitators of the learning sessions were not able to make their image of 'patient feedback' or 'quality improvement' entirely dominant (c.f. Hill, 2004). Rather, for the presenters of storyboards, their 'patient feedback', whether idiosyncratic or otherwise, gained in status by its inclusion in a 'formal QI' process such as the learning sessions while still being effective for those frontline staff who used it. This latter group were less concerned with the purity of the improvement process connected to essential definitions or of the 'one-off' nature of the feedback they act upon. For them, their actions *were* 'quality improvement' because those actions appeared on storyboards and were part of learning sessions; the lack of aggregated data for instance, did not hamper the ability of that data to lead to improvements in care. The concerns about purity and the appropriate qualities of patient experience data remained those of the facilitators.

When a service team introduced a concept such as 'flexing', which emerged from their own understanding of the reorganisation of their work, it was not recognised by their managers, arguably because it referred to nothing outside itself (and thus could not create an effect for the hospital). What could trouble such frontline teams is that they might not receive recognition for their work were it not for its inclusion in a formal improvement process; this might, for instance, in Sanditon have funding implications for their services and the level of autonomy in decision-making they were granted. But this concern is sufficiently addressed by their actions being part of the learning session, which is an authorised, formal activity, and an integral part of the nursing service assessment process.

The implications of these categorical distinctions and the search for their purity is clear in our discussion above about the use of an online message board as a source of 'patient feedback', presented by Sanditon's Community Nursing Team D at the learning session. The facilitators of the session suggested that, in Martin et al's terms, the data was 'wild' ('unpredictable…spontaneous' (2015: 25) and had been 'tamed' through its consideration by Team D and made recognisable through its participation in improvement activity and in the learning session process. They acknowledged and praised the way the team effected the data's transformation from 'wild' to 'tame'. But, as we noted, Team D itself did not regard the data in this way; they saw it as a non-dualistic category of 'patient feedback' (something it had always been) and presented it as such; it was neither 'wild' or 'tame'. Thus, it is the facilitators' attempt at categorisation – of the proper qualities of patient experience data that can properly lead to quality improvement – that sets up the distinction between 'wild' and 'tame' qualities. It is a distinction which is replicated by the literature discussed above (e.g. Martin et al., 2015; Montgomery et al., 2020) which explores the concerns such 'conflicting' qualities are said to pose for organisations. But this was not a distinction that was recognised by the nursing team themselves and not seen by them as critical in their work to act on patient experience data to improve care for patients.

Taking seriously the insights about flattening offered by ANT helps us recognise how taken-for-granted entities such as 'patient experience data' and 'quality improvement' are multiple, and gain qualities or characteristics in relation to each other. Importantly, these emerge through interactions which are observable through fieldwork and describable through writing. This aspect of ethnographic research – the writing of it – has received far less attention in the social science of healthcare literature than the fieldwork element (on the latter, see e.g. Cupit

et al 2018). The conventional style of most qualitative healthcare research – even of those which claim to be ethnographic in their methods of data collection – is resistant to 'staying with the description' in the writing of the article (see for example Montgomery et al 2020). Instead, the findings sections of such articles are often structured around interview quotes from entirely different sets of interactions both spatially and temporally, the writers interspersing such field data with appropriate 'context' to help the reader make sense of it (and sometimes not even doing that). We contend that this approach can miss the ways in which the objects of organisational ethnographic inquiry – in this instance - 'patient experience', 'data', and 'quality improvement' emerge as named things with qualities in any one field of scholarly vision.

A flattened, descriptive account such as this allows us to discern the presence of an alignment between different types of actors through patient experience data. This alignment is comprised of those who *must* get patient experience data to look a certain way and, through making associations between data and other validated concepts and practices (e.g. 'empowerment'), attempt to fashion new valued 'contexts' for its operation, which can properly lead to properly defined 'improvement'. These people include Kristina and other senior hospital staff but also those researchers who suggest 'operational fixes' to improve patient experience data, and which we discussed at the beginning. More strikingly perhaps, this alignment also includes those scholars who, while recognising the importance of capturing multiple voices in healthcare organisations, see wild and tame data as separate categories with stable definitions (e.g. Martin et al 2015; Montgomery 2020) rather than qualities that emerge in particular interactions. In the distinctions it names, such scholarly work runs the risk of replicating the categories that are relevant to managers only, asserting a universal binary where it might not exist. In this article, by way of contrast, we have attempted to describe the continuously emergent nature of an organisational process. We have shown how formalised, systemised mechanisms such as a learning session are not simply a process that uses already fixed, passive materials such as 'feedback' and turns them into actionable 'improvement'; neither does it produce singular agreed-upon definitions of these things as an outcome. Rather, the process *makes* 'data', 'patient experience' and 'improvement' as multiple practices having different qualities all in the same encounter. Thus, healthcare organisations and the scholars that study them need to be more attentive to the ways in which acting on data in standardised ways will constantly create new definitions and possibilities of such data, escaping organisational (and scholarly) attempts at mastery.

Areas for further research along the lines we have explored in this article might include looking at other forms of 'data' that are produced in healthcare settings such as those capturing safe care or staffing requirements.

The scholarly attempt at mastery in this area of healthcare organisation research is pursued with the aim of producing academic work that in its articulation of key principles, use or discovery of categories, and recommendations for action can be useful to healthcare practitioners and organisations in a range of contexts, helping them redesign patient experience data and quality improvement processes. However, this attempt to create practical change through supposedly actionable and nameable categories also means that the complex entanglements through which something like 'data' or 'feedback' emerges is left underexplored, leading to forms of misrecognition of what is going on. This article has attempted to redress the balance somewhat, advocating for the benefits of conducting ethnographic research on - and of writing detailed accounts of - restricted arenas in which the messiness of life in organisations can be adequately demonstrated and communicated.

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