The Point of Care Foundation

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Voices and stories are central to improving healthcare

The use of patient and staff narratives should be embedded across the NHS and social care system to humanise and improve the quality of healthcare, argues Bev Fitzsimons

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Two papers came across my desk recently discussing the importance of conversations, stories, and voices in the healthcare system. The first explores the value of conversations for driving quality improvement in healthcare.[1] The authors describe how conversations can be an important response to the complex environment of healthcare: a way of bringing complicated dilemmas to the fore, and allowing different perspectives to be held, rather than trying to resolve them.

The second is concerned with formal and informal approaches to ensuring employee's voices are heard within healthcare organisations.[2] If we agree (and surely few dispute it) that conversations—from a range of voices—can support quality improvement, this second paper asks important questions about what organisations can do to systematically embed methods to promote these conversations in the workplace.

But not all conversations are the same, and Wu et al describe two broad approaches to enabling conversations to take place. The first is institutional—formal channels within organisations for certain types of conversation. This might take the form of reporting procedures, a "'duty of candour" from clinicians or speaking to a freedom to speak up guardian (posts created under the auspices of The National Guardian's Office in response to recommendations made in Robert Francis QC's report "The Freedom to Speak Up").

But top-down approaches don't always work. As Wu et al write: "A notable finding of many investigations into complaints is the frequent dissonance between formally espoused organisational values of openness and listening, and the realities of what it's like to raise concerns at the sharp end."

This points to different types of conversation, generally categorized in the literature as either co-operative or competitive, and as being either one-way or two-way.[3] The purpose of competitive conversation is to persuade others to a particular point of view. In healthcare this can be seen in the heroic style of leadership in which pressure and persuasion are brought to bear on everything from bed management, waiting lists, and times to clearing care backlogs.[4 5]

Co-operative conversations, by contrast, are intended to exchange information and build relationships between those conversing. So using this latter definition, how can the use of narratives help to improve care quality?

Two of the Point of Care Foundation's key programmes—the patient experience (Sweeney) programme, which incorporates Experience Based Co-design (EBCD), and our staff experience programme (Schwartz Rounds)—include the sharing of narrative accounts of experiences of care, from both staff and patients. They provide a way to bring out stories in a safe and managed way, ensuring psychological safety. The unifying factor is that by sharing stories, the horizons of all those involved are expanded, a broader range of values and perspectives are valued, and relationships strengthened. Both enrich organisations' agendas because they bring people's lived experience to the fore, encourage dialogue, and connect people with their own humanity and that of others.

But both interventions are counter-cultural to the prevailing zeitgeist in the health system for they do not deliver quick fixes. They work through changing the nature of the conversation, seeking first to promote mutual understanding of each other's perspectives, to "open things up rather than close things down."[1]

At first sight, a key distinction between these interventions is that Experience Based Co-design is aimed at some sort of "problem solving" or improvement activity (for example, service re-design), whereas Schwartz Rounds are deliberately not about problem solving. But the ripple effects of Schwartz Rounds can address often unspoken problems, such as the denial of the emotional impact of working in healthcare; the sense of isolation sometimes felt by healthcare staff; fragmented and disjointed communication; and lack of connection between different parts of the system.[6] Clearly conversations need to be inclusive of voices and not exclude those that don't conform with the norm.

Experience Based Co-design and Schwartz Rounds involve carefully designed models to get round this potential problem. Adherence to the fidelity of their models are the means of mitigating these risks. This means they need to be set up and rolled out with care. Modest resources are needed to do this safely.

The idea that what constitutes "good" in healthcare consists of more than good biomedical outcomes has long been the view of the Point of Care Foundation. A key tenet of the Foundation's refreshed strategy is to "work with systems to change the culture of care, and to use patient and staff narratives to make the experience of care more human." We have written to the Chief Executive of NHS England and NHS Improvement, Amanda Pritchard offering to share these narrative practices with the Executive Board of NHS England. We believe these practices should be embedded across the NHS and social care system.

The emerging integrated care systems are the perfect vehicle for this.

Stories can be used to great effect to galvanise effort. They not only engage the listener, but they persuade too. They reflect the humanity that is fundamental to healthcare.

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1 Cribb A, Entwistle V, Mitchell P. Talking it better: conversations and normative complexity in healthcare improvement. *Med Humanit* 2021;0:1-9. doi: 10.1136/medhum-2020-012129 pmid: 34035179

2 Wu F, Dixon-Woods M, Aveling EL, etal. The role of the informal and formal organisation in voice about concerns in healthcare: A qualitative interview study. *Soc Sci Med* 2021;280:114050. doi: 10.1016/j.socscimed.2021.114050 pmid: 34051553

3 Angel D. (2016) https://davidwangel.com/the-opportune-conflict/2016/12/28/the-four-types-of-conversations-debate-dialogue-discourse-and-diatribe

4 Thomas R (2021). Hospital trust loses 'good' and 'outstanding' ratings amid ED pressures. HSJ 8th October 2021.

5 Smyth C, Wright O. (2021). Tory party conference: NHS bosses face sack for failing to cut waits. The Times 5 October 2021. https://www.thetimes.co.uk/article/tory-party-conference-nhs-bosses-face-sack-for-failing-to-cut-waits-gk26rgqm9

6 Maben J, et al. (2018). A realist informed mixed-methods evaluation of Schwartz Center Rounds in England. Southampton (UK): NIHR Journals Library; 2018 Nov. PMID: 30431750.