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Research

What are the sources of patient experience feedback in the UK prison setting, and what do patients and healthcare staff think about giving and receiving feedback in prison? A qualitative study

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Abstract

Background: The collection of patient experience feedback (PEF) has seen a marked global increase in the past decade. Research about PEF has concentrated mainly on hospital settings albeit a recent interest in primary care. There has been minimal research about PEF in the prison healthcare setting. The aim of this study was to explore the role of prison PEF, the different forms it might take and the perceptions of healthcare staff and people in prison. Methods: Qualitative face to face interview study involving 24 participants across two prisons (male and female) in the North of England, involving 12 healthcare staff and 12 patients. Framework analysis was undertaken. Results: PEF sources were variable, from informal and verbal through to formal and written. The willingness of people in prison to give PEF related to whether they felt sufficiently comfortable to raise concerns, with some feeling too frightened and having apprehension about anonymity. It was viewed as disheartening to give PEF but not be informed of any outcome. Healthcare staff opinions about PEF were divergent but they found PEF unhelpful when it was about prison regime issues rather than healthcare. Suggestions for improving the PEF process were put forward and included accessibility, anonymity and digitalisation. Conclusions: This is the first study to report findings about prison PEF. There are broad similarities between our findings and research examining hospital-based PEF. Prison healthcare services seem to be listening to patients but the ways in which PEF is collected, considered and used could be improved.

Keywords

Patient experience, patient feedback, prison, jail, qualitative methods, healthcare

Introduction

The last decade has witnessed a significant increase in the collection of feedback from patients regarding their experiences of healthcare services throughout many countries across the world. Several systematic reviews have identified a range of quantitative survey tools which are used to capture patient experience in an inpatient setting.[1,2] Included in this are whole healthcare system surveys such as NHS National Inpatient Survey in the UK. Major impetus has been given to the collection of the one question *Friends and Family Test* in the UK, which asks patients if they would recommend the service they have experienced to their friends and family members. A recent scoping review found 37 different types of patient experience feedback (PEF) 'on offer' to healthcare staff within UK hospitals including surveys, qualitative feedback initiated by the hospital and qualitative feedback initiated by the patient themselves.[3] Qualitative forms of feedback can be described as those such as complaints, compliments, thank you cards, online methods such as via the website Care Opinion in the UK.[3] Patient feedback about experience of hospital care gathers information most commonly about aspects of safety and quality.[4] Indeed, experience, safety and quality of care exist in a triumvirate wherein one often impacts and influences the other and are often considered as a group rather than in isolation.[4]

There has been recent research interest in examining the role of PEF in other settings outside of acute care, most noticeably community primary care. Primary care researchers have investigated: implementation of real time PEF in GP practices[5] how general practitioners felt about receiving feedback via patient experience surveys[6] and the role of patient safety feedback processes in primary care in Australia.[7] As the interest in PEF has spread outside of acute healthcare, recent studies have focused upon patient experience in a mental healthcare inpatient setting[8] and also a hospice setting.[9] Recently, Edge et al. (2020) have paid attention to the patient experience of patients in

prison who need to access acute hospital care and found delays and a lack of a person centred approach.[10]

To date, there has been minimal research which focuses on patient experience in prison settings. There is an evidence base regarding *the lived experiences* of people in prison with respect to use of healthcare services, but patient experience as a concept is poorly articulated. Where experiences of healthcare have been examined, it is often in relation to a specific health condition, identity or healthcare service, such as older patients' experiences of accessing medication in UK prisons,[11] the healthcare experiences of transgender women in prison in America,[12] older peoples' perceptions of their healthcare in prisons in Switzerland,[13] the use of telemedicine in prisons in the UK to improve quality and access to care[14] and patient's experience of managing cardiovascular disease in America.15 Notable exceptions in this regard are Plugge et al. (2008) and Capon et al. (2020) who both examined patient experience as a general concept.[16, 17] Plugge and colleagues conducted a qualitative study about women's perceptions of the quality of the healthcare in UK prisons. Capon and colleagues focused upon the barriers and enablers regarding access to healthcare for people in prison in Australia.

Whilst the movement to pay attention to PEF has reached a zeitgeist moment in the hospital setting[18] and is gathering momentum in other settings, the prison healthcare environment has been overlooked in this respect. The prison environment has not traditionally been part of patient experience research and the authors are unaware of any literature globally about patient experience *feedback* in the prison healthcare setting. The aim of this research was to explore staff and patient perceptions of PEF in the prison healthcare setting, through qualitative interviews.

Methods

Study design

We conducted an inductive qualitative study, using in-depth interviews with both healthcare staff and patients.

Ethical approval

Approval was received from the National Health Service (NHS) and the prison service (National Offender Management Service) to conduct this study. NHS North East & York Research Ethics Committee, 19th August 2016, Ref: 16/NE/0264. NOMS committee, 7th October 2016, Ref: 2016-300.

Study setting

Two prison sites were involved in this research: a closed female prison in the North West of England and a medium security male prison in the North East of England. These prisons were chosen to represent the female and male estate in different geographical areas and were also two of the 12 prisons which the researchers had security approval and appropriate Ministry of Justice permissions to access in their wider research roles.

Sampling

Twenty-four participants were interviewed for this study which is the point at which the researchers felt that no new information was being retrieved, based on fieldwork impressions. The breakdown of this recruitment was: 7 staff and 8 patients at the female prison and 5 staff and 4 patients at the male prison. Patient participants were sampled on age and use of healthcare with staff participants sampled on levels of seniority and duration of time they have practised within the prison healthcare environment.

Data collection

People in prison were approached whilst they were in the waiting area of the healthcare unit of the prison and the researcher approached them with a verbal explanation of the study. If an individual appeared interested in taking part, they were provided with a participant information sheet to read. Sensitivity and diplomacy were paid to literacy issues and, where necessary, verbal assistance was provided to ensure participants had a comprehensive and informed understanding of the purpose and conduct of the study. Particular emphasis was placed on the fact that declining to take part in the interview does not affect future healthcare provision and is not related in any way to length of prison sentence or parole. Participants were assured that the interview was confidential. Eligibility criteria constituted any experience of receiving prison healthcare. We did not specify that people in prison needed to have previously given feedback regarding their healthcare experience since not providing previous feedback was an issue of research interest. Healthcare staff were recruited through senior medical personnel who engaged with staff to ascertain who may be interested in the study and then passed back expressions of interest to the researcher who then contacted the staff member individually. Again, the initial approach was verbal and then written material was left with the potential participant if they expressed an interest in taking part.

Interviews took place between March and December 2017. Interview length was between 14 and 45 minutes. All interviews took place face-to-face, within the prison estate, and were conducted one to one with a qualitative prison researcher. The first author conducted the interviews in the female prison, and the second author conducted the interviews in the male prison. Written, informed consent was obtained from each participant. The interviews were digitally recorded and transcribed.

Interview questioning

All interviews were conducted using a topic guide to ensure consistency across participants; however, the

format was flexible in order to allow participants to voice what they considered important. Interviews with patients began with a brief description of their use of prison healthcare services to understand context and then went on to ask regarding the process of feeding back any opinions about their healthcare experience (positive or negative), via any format, and any responses to such feedback. Interviews with staff began by asking what types of patient feedback the staff are aware of, appraise, and act upon and went on to explore how easy or difficult it was for healthcare staff to act upon instances of feedback.

Analysis

A Framework analysis[19] was undertaken. Data analysis involved a process of organising the data, descriptive coding, charting the data and then interpretation. The first author and the last author held several 'analysis sessions' where they came together to discuss analysis structure and content after having each read five transcripts. The first author then coded all transcripts and interpreted the data, sense checking with the last author where appropriate. The last author wrote up the findings into a publication format.

Findings

First, we will describe the main sources of PEF which participants discussed during their interviews in order to provide context. Second, the perceptions of people in prison regarding the giving of PEF and third, staff perspectives of receiving PEF, will both be explored. Finally, we look at what could be improved upon regarding prison PEF.

1. What are the main sources of patient experience feedback in the prison setting?

We found there were a variety of differing ways of people in prison being able to provide feedback regarding their experiences of healthcare, ranging from informal and verbal through to formal and written. These took the forms of: patients simply talking to healthcare staff, thank you cards, complaints, compliments and a formal Health & Wellbeing forum attended by both patients and healthcare staff (the latter only took place in the female prison).

Informal verbal feedback*:* Female patients described giving informal face-to-face feedback as an easy process because they felt able to 'drop into' the healthcare department and submit spontaneous informal feedback at their convenience. In the male establishment, there appeared to be fewer avenues for informal verbal patient feedback, with patients having to seize ad-hoc opportunities to provide feedback, such as when clinicians are either on the wings, or at the medication hatch. The spontaneous nature of this feedback process in the male prison raises concerns, for instance, if someone has conflicting commitments such as attending court at the time that clinicians are present on the prison wings, then an opportunity for providing feedback will be missed.

Written feedback: In both prisons, patients and staff talked through the various forms that can be completed for submitting a complaint or a compliment regarding the healthcare department. There were variances in how these forms are typically accessed with the forms predominantly within the healthcare building at the female prison and the forms being situated on the prison wings at the male prison. Several clinicians from the female prison talked about receiving thank-you cards and notes from patients praising their work. Staff interviewees from the male prison did not mention having received such tokens of gratitude.

Formal verbal feedback: The female prison had a formalised Health & Wellbeing forum (called the "Queensland meeting") where healthcare staff and patients were invited to discuss general issues regarding healthcare provision. Interviewees explained that this is not a mechanism for individual based complaints or concerns. Female participants spoke highly of this forum as they felt it gave patients a voice that could benefit the healthcare service.

2. What are patients' perceptions of giving patient experience feedback in prison?

Participants varied in their willingness, enthusiasm and motivation for giving PEF. Overall, when participants felt that they were given a voice by the feedback process to express their concerns and issues then they responded to this with enthusiasm. This was more likely to occur in the female rather than the male prison.

I will always try my best to give positive feedback where it's needed, like, with the nurse yesterday (Participant 14, Patient, Female prison)

The Health & Wellbeing forum at the female prison was roundly praised as a method of giving people in prison a real voice to enable their feedback to improve prison healthcare services. Patients share their first-hand experiences of using prison healthcare services and to feed back their improvement suggestions and change requests. Such feedback has influenced the healthcare department's decisions to adjust medication dispensing and has helped to reshape intervention clinics. The meetings were described as leading to real, positive change with one clinician explaining that feedback was taken seriously and acted upon:

It was good because the girls were feeding back different things. They were feeding back about how many meds they can have in IP [in possession], to reduce the meds queue, and if girls attended the stop-smoking clinic and they fell of the wagon, how long it would be before they could actually restart that clinic again, the times of medications,

whether it was feasible to have methadone in the morning or methadone in the evening, because we always have to work with the prison regime, you know. It is the prison first, healthcare second. They take it all on board, what they say (Participant 5, Healthcare Assistant, Female prison)

A deciding factor is whether to give PEF was whether clinicians were seen as approachable and accessible and whether patients' felt it was easy to voice their concerns. Ultimately, it seemed to come down to whether individuals felt sufficiently *comfortable* to express concerns. Indeed, some participants did not appear to shy away from sharing their concerns or issues. When Participant 12 was asked if she had ever made a complaint, she responded: *"Loads, I've made about 20 over the years".*

In contrast, some participants described how they felt too frightened to give negative feedback in fear of the origin of the complaint being revealed to staff and knew of others who also felt this way. Concerns were raised by some about the anonymity of written feedback. It was stated that some people might feel too awkward to deliver negative feedback if they suspect that staff might deduce who the complaint came from:

There's no specific complaints box for healthcare. You've got your complaints form which you can put in an envelope… So in theory, they have to either put it into the res hub [Resolution Hub} who then pass it on or they have to go and deliver it. Now, if your complaint is about that receptionist, that's awkward (Participant 14, Patient, Female prison)

Participant 8 highlighted that making a complaint regarding a particular department can be frightening if it has to be carried out in the same physical space of the department itself. The same participant explained that trying to give feedback in a prison healthcare waiting room can be a frightening experience whilst in the presence of distressed and unwell people.

For those who did feel comfortable giving PEF, most participants reported feeling frustrated when they gave feedback but were not informed of the outcome. Although some participants placed a relatively high value on *giving* feedback, there was a narrative that suitable outcomes are rarely achieved to resolve complaints which fuelled a resultant attitude of "what is the point in giving feedback?"

Nothing ever comes from them. You don't ever get any, they don't ever come and give you feedback on your information that you gave or anything, so there's not really any point (Participant 17, Patient, Male prison)

I'm sick of doing it… It's like my applications, all my complaints get lost or ripped up. (Participant 12, Patient, Female prison)

Echoing both female and male patients' disheartened view of not hearing back about feedback they had given was the confirmation from some healthcare staff lack of time and resources to properly dealing with complaints and concerns.

Getting patient feedback is important but there's a line around the resources it takes to manage all the feedback and co-ordinate all the feedback, against, well actually while they're doing that, they're [staff] not delivering the care and that seems to be a bit of an obsession with it, to be honest (Participant 20, Pharmacy staff, Male prison)

Despite the enthusiasm for the Health & Wellbeing forum at the female prison, there was also a sense of disappointment and frustration from some patients who explained that many issues are either 'rolled over' and/or persistently categorised as 'in progress'.

Finally, a finding emerged regarding a perception that giving feedback was a process that needed to be 'learned'. This learning process appeared to happen in one of three ways: being taught by peers such as 'orderlies' (a role where people in prison support others); being made aware through 'induction' literature received on arrival into the prison; or simply learning independently, over time. One concerning point of interest that was raised by some participants suggested that some people do not learn about how to give feedback until long after they have arrived in the prison. Participant 14 asked when she had been made aware of the patient feedback process and she replied: "*I would say it was probably six months to a year after I'd been here."*

3. What are healthcare staff perceptions of receiving patient experience feedback?

Healthcare staff appeared to be divergent in their opinions regarding whether they welcomed receiving PEF or were ambivalent towards it. Even for those who were enthusiastic about receiving feedback, this was often cloaked in caveats. A major frustration for this group focused on how PEF was mainly considered to be an issue which management dealt with and responded to, whereas lower staff grades were left out of the process:

The complaints, generally, go to matrons and above. A band six [junior nurse] can look at them, but I think it's only the matrons and the band sevens [senior nurse] that actually deal with those complaints… I don't really get to know about much feedback at all, unless we have a staff meeting and it's brought up in a staff meeting (Participant 5, Healthcare Assistant, Female prison)

Staff explained that some PEF is unhelpful when the feedback relates to issues that are a result of the prison regime and cannot be changed by healthcare staff. For example, when patients are dissatisfied with medication dispensing scheduling that has been implemented by the prison, there is little that healthcare staff can do to change

this as they are required to work around the prison regime. Indeed, this was reflected by one clinician who explained that many patients become angry that they cannot access the same types and/or amounts of medications in prison as they are used to out in the community.

We do have to medicate early, at weekends. Because, of the lack of staff later on in the day. So, obviously, for the prisoners, for the girls, I think, you know, it does seem unfair, that we are having to give out medications that they wouldn't necessarily take at that time, at home, you know. We're having to do that early. So, I think that can be unfair. But, we're sort if, in a position, where we can't really do a great deal about it. Because, we can't then do another drug round, later on, because there's not the officers to facilitate it, really (Participant 15, Senior Nurse, Female prison)

On the contrary, across both sites, healthcare staff explained that patients are given notice before any alterations to health services are made (which healthcare staff have control of), allowing them the opportunity to query the changes before they take effect:

We changed the guidelines for prescribing gabapentin [opiate medication]. All the patients that are on gabapentin received a letter to tell them about the changes. So as far as I'm aware, if there's any changes, they do get a letter beforehand (Participant 23, Complaints staff, Male prison)

Perhaps unsurprisingly, PEF processes were described as difficult to manage within prisons. One clinician in particular, explained that PEF is not easy to facilitate in secure settings where it is typical for incumbent healthcare providers to change over time. Another cited barrier to obtaining PEF relates to it being received in a negative manner. Clinicians from both prisons explained that often feedback was delivered in an abusive way which makes for an unpleasant experience.

You get called everything on the [feedback] form… if you take it personal, you wouldn't come back in… it's hard sometimes (Participant 7, Staff nurse, Female prison)

I know that we expect it in custody, and we expect it with the people that we work alongside, but we still don't come to work to be abused. And every single member of staff on this healthcare team gets abused at least once a day. I've had somebody swearing at me today, spitting in my face, they were talking to me that vile (Participant 10, Healthcare Assistant, Female prison)

4. What could be improved regarding prison patient experience feedback?

Both participant groups were keen to put forward suggestions for how the delivery and receipt of PEF could be improved. Within the male prison, there was a view among some patients that feedback tools should be more visible and accessible for them on the prison wings. One patient suggested going so far as having paper forms available in each cell to avoid a delay in submitting feedback, in addition to removing the need to visit the wing office:

There should be, like, where you can take them off your cell though, instead of having to go into the office… they should be in front of you, so you can just take one yourself, instead of waiting (Participant 18, Patient, Male prison)

Regarding the issue raised about anonymity and PEF, it was proposed by several patient participants that a separate feedback box is located away from the healthcare department so that those who want to make a complaint using this method, are less visible to healthcare staff:

It's a very small space of time that you're in there [healthcare department] and you're in there and it is a small area, it's about as big as this, it's a small area and there's quite a few of you waiting, so you might not feel comfortable enough to fill a form in there and put it in the box there. Whereas if it was somewhere else which isn't linked to that…maybe it's not as scary. (Participant 8, Patient, Female prison)

Digitalisation of PEF was discussed by staff with the increasing use of technology in cells such as laptops which people could use to manage their stay in prison and undertake tasks such as booking visits. It was felt that increasing means of digital access for people in prison meant that PEF could potentially be delivered via this manner, and the PEF given would be inherently more 'real time'. However, the prison environment itself represents a barrier to PEF ideas that are already prevalent in community healthcare, as one staff member discussed:

There's lots of suggestions about having mobile apps that you can have on to get feedback. It doesn't really work in a prison. So we've not got the mechanisms within a prison setting to get really timely feedback. So you know if you go to your GP or dentist, you may well get a text message asking you to rate the care you received that day between one and ten…You can't do that in prison. So often, the feedback is not as timely as it could be because you've not got the flexibility (Participant 23, Complaints staff, Male prison)

Finally, a Healthcare Assistant said they thought it would be useful for people in prison to receive an information booklet from the healthcare department when they first arrive in the prison, which may seek to address common issues often relayed via PEF:

Initially, when they first arrive to prison… from a healthcare side of things, maybe a booklet for healthcare. You know, if you have got any issues and what those issues are. So, maybe if there was something produced, especially for first time offenders, because when somebody first comes into custody, they haven't got a clue (Participant 5, Healthcare Assistant, Female prison)

Discussion

We found a range of PEF sources existed within the prison setting, both formal and informal, written and verbal. Overall, people in prison felt able and willing to give PEF when they felt that staff were approachable but there were concerns about anonymity and frustration occurred when the outcome of giving PEF was unknown. Healthcare staff diverged in their views about receiving PEF and found it to be unhelpful when the PEF given was about issues related to the prison regime rather than the healthcare department. PEF was perceived to be an issue that only management dealt with, and PEF had previously been delivered to healthcare staff in an abusive manner. Suggestions for improvement were given which involved comment about the increasing digitalisation of health services.

This is the first research study to understand PEF within the prison setting, as far as the authors are aware. There are several broad similarities between what was found in this study and the wider literature regarding feedback for healthcare provision in hospitals and the community. Lack of staff time and resource and the inability to change parts of the healthcare system to make improvements have been documented in literature about acute hospital care.[18, 20, 21] Previous literature has found that hospital healthcare workers have felt overwhelmed by the volume and variety of patient feedback that they are expected to engage with.[18] This was not a finding which emerged from this current study and therefore may indicate that the collection of feedback in the UK prison setting is currently pitched at an appropriate level and has not yet encountered some of the pitfalls which have occurred in the acute sector. Likewise, it is encouraging to see that whilst the differing environment of the prison setting introduced its own challenges, the setting does *not* seem to introduce contextual factors which render the PEF process an impossible task.

Receiving feedback from patients about their healthcare and staff having the ability to act on this is the cornerstone of a continuous quality improvement culture. The role of prison healthcare in addressing addiction and illness is crucial in reducing re-offending and cutting crime in the community.[22] Recommendations for practice can be separated into a) practical measures and b) identification of the cultural determinants of when feedback is both given freely and appreciated. The latter is hard to distil into operational findings but important, nonetheless. In practical terms, the Health & Wellbeing meeting was judged to be a highly successful forum where patients felt they had an active voice in healthcare concerns and staff worked together with them to try and resolve issues. Practical learning about how to form and conduct this meeting format could be spread to other prisons which are interested in placing the patient voice at the forefront of healthcare delivery. The understandings that people in prison have of prison healthcare and its processes could be managed through the provision of an explanatory booklet at reception into prison. Further, information could be provided in the form of "frequently asked questions" via written or video sources so that repeated PEF is not given about the same issue.

More broadly, closing off the feedback loop (so that patients know the outcome of the feedback they provided) seems to be an important part of an individual's decision to provide feedback in the first place. The female prison had a culture of healthcare staff being considered highly approachable and there were diverse ways in which feedback could be given, alongside more opportunities to do so. Whilst difficult to emulate, this establishment showed what could be done when patient feedback is prioritised and patients are made to feel that their feedback is valuable. Patient representatives on the Health & Wellbeing forum could also be supported to take on a role of providing individualised feedback in some cases where an appropriate response is an explanation regarding the prison regime or healthcare policies.

Perceptible differences existed in the culture and structure of the two prisons. In the female prison, there was more enthusiasm for giving feedback and healthcare staff were viewed as being accessible, approachable and facilitative. In contrast, in the male prison, there were fewer avenues for informal feedback (people in prison had to catch a clinician on the wing or at the medication hatch) and the process of giving feedback was perceived more negatively. It is unclear whether these differences were related to gender, prison category or establishment characteristics (the female prison was smaller than the male prison). Interviewees in the female prison discussed the Health & Wellbeing Forum, which had a great deal of positivity attached to it and it was seen as a vehicle to gather useful feedback that could result in real world improvements. There was no such forum at the male prison. It could be that the female establishment is better equipped to offer this service as it houses less people and therefore less resources are needed to hold the meetings. Additionally, the two prisons are likely to follow different processes and have different priorities and ideologies. It could be that the prison regime at the female establishment places more value on PEF, hence staff are more likely to actively seek patients' views. However, the individual organisations' priorities were not part of interview questioning or explicitly discussed so definitive conclusions cannot be drawn.

Strengths and Limitations

The author team believe this to be the first paper globally which reports empirical research findings about PEF in the prison healthcare setting. This study used qualitative

in-depth, semi-structured interviews with both staff and people in prison to gather insights from both perspectives regarding prison patient feedback processes. In-depth interviews represent one of the best possible ways in which to access people's experiences and opinions.

Due to confidentiality issues, researchers were not able to attend or observe the Health & Wellbeing forums within the female prison. It could have been insightful to attend such a session in order to learn how feedback is acted upon within this format. The study was conducted in two prisons in the North of England and therefore the findings may not have applicability to prisons internationally that reside within healthcare systems and funding models that are different to the UK.

Conclusion

We conducted a qualitative interview study with prison healthcare staff and people in prison. We found that a range of PEF sources exist in the UK prison setting. We explored the perceptions of people in prison regarding the giving PEF alongside the perceptions of healthcare staff of receiving PEF. Suggestions for improving the PEF process were put forward. We believe this is the first paper globally to examine PEF in the prison setting.

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Author Contributions

Conceptualisation, design and acquisition of funding (LS and NW). Data collection (FH and GC). Access to and liaison with sites (PH). Data analysis (LS and FH). LS and FH wrote the first version of the paper then all co-authors read, commented, made edits and approved the final manuscript.

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