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A glimpse behind the organisational curtain: A dramaturgical analysis exploring the ways healthcare staff engage with online patient feedback 'front' and 'backstage' at three hospital Trusts in England

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Abstract

Healthcare staff are encouraged to use feedback from their patients to inform service and quality improvement. Receiving patient feedback via online channels is a relatively new phenomenon that has rarely been conceptualised. Further, the implications of a wide, varied and unknown(able) audience being able to view and interact with online patient feedback are yet to be understood. We applied a theoretical lens of dramaturgy to a large ethnographic dataset, collected across three NHS Trusts during 2019/2020. We found that organisations demonstrated varying levels of 'preparedness to perform' online, from invisibility through to engaging in public conversation with patients within a wider mission for transparency. Restrictive 'cast lists' of staff able to respond to patients was the hallmark of one organisation, whereas another devolved responding responsibility amongst a wide array of multidisciplinary staff. The visibility of patient-staff interactions had the

potential to be culturally disruptive, dichotomously invoking either apprehensions of reputational threat or providing windows of opportunity. We surmise that a transparent and conversational feedback response frontstage aligns with the ability to better prioritise backstage improvement. Legitimising the autonomous frontstage activity of diverse staff groups may help shift organisational culture, and gradually ripple outwards a shared responsibility for transparent improvement.

KEYWORDS
digital health, dramaturgy, ethnography, healthcare, patient centredness, patient experience, patient feedback, patient involvement, patient safety

INTRODUCTION

Healthcare staff are encouraged to engage with patient feedback regarding their experiences of care (NHS Patient Safety Strategy, 2019). Traditional feedback sources, such as national surveys and complaints, have been widely researched, and they highlight a complex web of sociocultural barriers that face staff who might want to use this information to improve services (Donetto et al., 2019; Flott et al., 2016; Locock et al., 2020; Martin et al., 2021). For instance, Sheard et al. (2017) proposed the Patient Feedback Response Framework, suggesting that first, staff must exhibit normative legitimacy by personally believing in the importance of patient feedback. Second, structural legitimacy must be in place, requiring perceptions of sufficient authority and autonomy to enact change. And finally, organisations must display a readiness to support teams and have capacity for improvement.

In addition to feedback deliberately elicited from patients via surveys or other mechanisms, patients can also report about their healthcare experiences in an unsolicited manner online, on publicly available platforms. This extends the potential reach of information to much wider, varied and unknown(able) audiences, including, but not limited to, other patients, healthcare staff, senior management, commissioners and regulators. This may result in staff not only feeling pressure to collect, hear and learn from patient feedback, but also to do so promptly, transparently and personably (Powell et al., 2019). Montgomery et al. (2022) described how the digital reach of online patient feedback may extend 'gaze' beyond isolated patient-healthcare interactions in primary care. Rather, staff perceive that gaze transcended to a public forum, encompassing much more of the healthcare service in its entirety, having the potential to disrupt power relations. Staff also adopt divergent styles of responding to online feedback, ranging from not providing a response at all through to engaging in transparent conversation, which is seemingly determined organisationally (Ramsey et al., 2019), and favoured from the patient perspective to varying extents (Baines et al., 2018).

The limitations of traditional patient feedback sources include their restricted visibility and scope to capture complex realities (Robert et al., 2018), often reducing patient experiences to organisationally contrived senses of accuracy as 'quantified control potentially undermin[es]

the very goals it is meant to further' (Levay et al., 2020). Overcoming 'seductive' temptations to quantify information and embracing unsolicited online feedback methods, align with calls from Montgomery et al. (2020) for the 'rewilding of patient experience data'. Less formal, nuanced intelligence gained from patients has shown to be a powerful way of gaining holistic understandings of humanised patient experiences and form the bases for interventions (Martin et al., 2015; Waring & Bishop, 2010). Nevertheless, the implications of placing patient-staff interactions online remain largely unknown.

Conceptual framework

Goffman's (1959) theorisation of social interaction, dramaturgy, provides a potentially illuminating lens to view online feedback and may enable more thorough understandings of how care quality and safety can be shaped by wider sociocultural contexts (Allen et al., 2016). Dramaturgy likens social interactions to performance, comprising a front and backstage, with impression management of the two being essential. Goffman illuminated how everyday interactions are often intricate interpersonal exchanges comprising unacknowledged rituals, strategic relations and unspoken understandings. Such underlying engagements of reciprocal influence involve the simultaneous presentation of the self via displays of impression management techniques, while actively forming critical judgements of others. For example, a patient aiming to portray themselves as an effective communicator and attentive listener, whilst being concerned with a healthcare professionals' trustworthiness and compassion.

The term 'performativity' has been used to explain how expression constitutes action which alters reality, rather than simply describing it (Austin, 1962), which is a feature of social actions being carried out in ways that they are 'not only done, they are done so that they can be seen to have been done' (Button & Sharrock, 1998; Garfinkel, 1952). According to dramaturgy, the self is, therefore, an artefact of impression management to a particular interaction, often formed backstage before performances are ready, with both conscious rehearsal and implicit preparation. Hochschild's theory of emotion work (1983) suggests that performances often involve emotional management to present in a socially desirable way, aided by what Goffman termed 'common social scripts', defining how individuals should act (1967).

Goffman made an important distinction between how individuals behave front and backstage. 'Frontstage', actors must maintain expressive control and perform in ways that may not be fully representative of the true self, but 'the self we would like to be' or will achieve the desired audience response. Social dynamics are argued to be largely determined by abilities to 'maintain face', which may involve degrees of cynical performance. Alternatively, performances can be knowingly contradicted 'backstage', where 'illusion and impressions are openly constructed'. Actors can temporarily relax and 'step out of character' by metaphorically adjusting costumes, preparing scripts, rehearsing lines and letting off steam. Maintaining clear separation between the regions hides the 'dirty work' that goes on behind-the-scenes and avoids audiences viewing performances inconsistent with those meant for them, considered 'the place where a performer can reliably expect that no member of the audience will intrude'. Goffman argued that audiences are often prepared to overlook minor anomalies, but are less tolerant of larger, repeated inconsistencies which risk 'shaming face'. Where actors are met with audience cynicism, they may make adjustments. For instance, a nurse displaying disregard for a patient may 'save face' with an apology, explanation or not repeating the mistake. However, continuous disregard may disillusion perceptions of a caring professional, with potential implications for how they and their wider team are viewed.

Goffman proposed that managing multiple audiences and goals makes performing especially difficult; as 'problems sometimes arise... where the same or different members of the team must handle different audiences at the same time' (Goffman, 1967). Pressure may also cause energy to be moved from the 'doing' to the 'communication of the doing'. Nonetheless, 'those who have the time and the talent to perform a task well may not, because of this, have the time or the talent to make it apparent they are performing well'. For instance, staff aiming to use online patient feedback to inform improvement may momentarily, or continuously, sacrifice communicating that activity online. The preformative role of individuals is also important, for instance, healthcare assistants may rarely respond to online feedback yet be highly concerned with activity, whereas communications staff with no involvement in activity may fulfil purely preformative roles, termed by Goffman as 'window dressing'.

Based on the outlined issues, the aims of this study were to:

(1) Understand the implications of placing patient feedback online to potentially large, varied and unknown(able) audiences.
(2) Explore what online responses to patient feedback tell us about the organisational 'backstage'.

METHODS

Ethical approval to conduct the study was received in 2018 from the Faculty of Medicine and Health Research Ethics Committee at the University of Leeds (no. PSC-444) and the study was draughted in accordance with the consolidated criteria for reporting qualitative research (COREQ) (Tong et al., 2007). Authors have backgrounds in sociology, psychology, quality and safety, improvement science and applied health services research. A reflexive diary was kept to record how interpretations were formed and ensure that they were warranted by the data. The data that support the findings of this study are available from the corresponding author upon reasonable request.

Case selection

Three NHS Trusts were selected using a critical case sampling strategy, enabling the research questions to be explored within distinct contexts. This was determined both pragmatically (travel to and from site possible in a day), and theoretically, using Ramsey et al.'s. (2019) pre-defined typology of responding to online patient feedback via Care Opinion (www.careopinion.org.uk) (see Table 1). Care Opinion is a prominent online platform available in the UK, on which patients can provide unsolicited narratives regarding their care experiences and relevant stakeholders, such as staff within healthcare organisations, can respond. Every NHS Trusts in England is provided with two free staff accounts, enabling them to provide responses. Organisations can subscribe to Care Opinion to increase the number of staff able to respond. Patient feedback and staff responses can be viewed publicly. A non-responding organisation (site A), a generic responding organisation (site B) and an organisation that provided transparent, conversational responses (site C) were recruited to ensure variation (Ramsey et al., 2019). This was done to offer rich information around the underlying phenomena and their causes and consequences, which randomly selected cases seldom do (Flyvbjerg, 2006). NHS staff within the identified Trusts were initially approached via email, and snowballing and opportunistic sampling methods

TABLE 1 Online feedback response types.

	Non-response type (adopted at Site A)	Generic response type (adopted at Site B)	Transparent, conversational response type (adopted at Site C)
Definition and context (Ramsey et al. (2019)	A minority of patient feedback narratives posted on Care Opinion did not receive a response (11.8%). Response rates varied between organisations; however, some were overall non-responders. Where a response was not provided, it was unclear if staff were listening or able to learn from the patient narratives 'backstage'.	Despite representing a relatively low percentage of responses given (10.5%), generic responses were provided by few organisations to all feedback posted regarding their services. These lacked personalisation, yet often appeared to have been purposefully designed to appear conversational. They often gave superficial thanks, 'non-apologies' or vague promises to pass on feedback, without specific information regarding who would be involved, how this would be done, and when. It remained unclear if the feedback had been fully considered, understood or learnt from.	Transparent and conversational responses were least commonly provided (6.5%). They involved staff outwardly engaging with patients, seemingly valuing their feedback and embracing the opportunity to learn publicly. They often appeared compassionate and transparently discussed barriers to any direct impact the feedback could have. Staff tended to communicate the journey that the patient feedback had taken, or more often, would take. Feedback receiving a transparent, conversational response in the first instance was most often in receipt of multiple responses.

were used to further recruit staff members who had, or may be expected to have, an interest in online patient feedback within each Trust.

Ethnographic approach

A focussed ethnographic approach (Knoblauch, 2005) was adopted during a year of fieldwork from March 2019 to March 2020 via an iterative and continuous process of data collection, analysis and reflection. Fieldwork comprised 25 semi-structured staff interviews (7 interviews at site A, 8 at site B, 10 at site C), observations of practice (12 h at site A, 23 at site B, 34 at site C) and documentary analysis of relevant information sources (6 source types site A, 9 at site B, 20 at site C). All interviews were guided by a schedule helping to focus conversation on topics including the role of online feedback within their job, service and organisation, the value of online feedback in comparison to other feedback sources, their approach to responding to online

feedback, their satisfaction with that approach, what they would like to improve with regards to online feedback and what others could learn from them and their organisation. The schedule was iteratively developed, piloted and refined by authors with input from the chief executive of Care Opinion. Observations of relevant practice included formal and informal meetings, events and training sessions, during which online feedback was directly or indirectly discussed and/or acted upon. Routine activity within patient experience offices, PALS offices and communications offices were also observed to understand the wider contexts in which staff worked. Case studies and multi-case analysis of the data set are explored elsewhere (Ramsey et al., 2022).

Dramatugical analysis

Previously, dramaturgy (Goffman, 1959) has been used to explore enacted dimensions of the governance of patient safety (Freeman et al., 2016), dynamic teamwork in the clinical backstage (Ellingson, 2003) and conceptualise the role that technology plays in determining how social spaces are bounded and connected, how interactions are mediated and the sorts of social interaction permitted frontstage (Pinch, 2010). But to the authors' knowledge, it has not been considered in relation to online patient feedback. Dramaturgy did not inform the original methodology or analysis, but was considered once data collection was complete as a seemingly intuitive way of gaining new insights. An abductive approach to qualitative analysis was taken, with a key aim of revisiting the studied phenomena in light of existing theory and sensitising the theoretical approach (Timmermans & Tavory, 2012), based on the premise data is then 're-experienced' in different ways (Marion, 2002). This involved the creative, inferential engagement with empirical data, existing case studies and multi-case analysis (Ramsey et al., 2022, 2023) and iterative consideration against the background of dramaturgical concepts within existing sociological theory (Freeman et al., 2016; Goffman, 1959; Hajer, 2005). All data sources were drawn upon throughout the analysis; however, representation of data sources was not necessarily equal, and all sources were not necessarily represented, but included dependent on data quality and significance. The four key concepts of dramaturgy namely scripting, setting, staging and performance, provided a heuristic tool to reframe ideas beyond the purely inductive analysis of data itself (Coffey & Atkinson, 1996). At each stage of analysis, decisions were discussed between all authors before iterative revision and a detailed log was kept throughout.

Scripting refers to backstage preparatory activity and the way in which participatory practices themselves construct participants as either active or passive, collaborators or protesters and competent or incompetent. *Setting* refers to physical environments and contexts in which actions and interactions take place, including props brought to environments, where settings themselves have a preformative dimension in influencing acts. *Staging* refers to deliberate attempts to organise interactions between participants, together with conventions governing distinctions between active players and passive audiences, the unwritten rules of engagement and the manipulation of what appears backstage and before the audience. Finally, *performance* refers to the activity that actors are willing to perform frontstage and the way in which the situated interactions themselves construct new knowledge, understandings and power relationships, which shape future interactions.

FINDINGS

First, summaries of the organisational context, structure and network of actors involved at each site are presented, alongside field note and documentary excerpts. Findings are reported using dramaturgical language. For instance, 'actor' refers to anyone undertaking social action, 'perfor-

mance' refers to social action undertaken in the view of others, 'cast' refers to a group of actors and 'audience' refers to anyone viewing social action.

Site A: Non-responder

Site A did not tend to respond to patients who gave their feedback via Care Opinion (Ramsey et al., 2019). The Trust operated via two hospital sites providing predominately acute healthcare services. There was no formally designated patient experience team, but the head of patient experience managed a small team of PALS and complaints staff originally spread across two sites, but merged during fieldwork.

> The walls of the small team office space were decorated with paper displaying statistics. In informal conversation with the team, these were referred to, to evidence the volume of 'unmanageable' patient feedback traffic they were dealing with – and in routine practice, to themselves and colleagues who entered the room. Staff referred to online feedback being something they felt they did not have time to consider, and even if they did, it was a 'dangerous space' where unidentifiable people could publicly undermine their staff. However, in interview, one of the PALS staff shared how they felt that online feedback was a missed opportunity to listen.
>
> [Site A, field note]

At the end of fieldwork over 2120 patient narratives had been posted to Care Opinion regarding the organisation; however, the response rate was 0% at the beginning of fieldwork. Sporadic engagement using generic responses midway through fieldwork increased the response rate to 8% in September 2019. The Trust had two registered Care Opinion users—the head of patient experience and a PALS officer, who intermittently gave the following generic response:

> If you need to discuss our services further, please do not hesitate to contact our Patient Advice and Liaison Service (PALS) and they can be contacted on: Telephone: [XXXXXX] Email: XXX@nhs.uk Online: [link]. Thank you once again for taking the time to provide us with your views on the local NHS services.
>
> Kind regards
> Patient experience
> Department [X] NHS trust

Site B: Generic responder

Site B provided 'generic' responses to every patient feedback narrative posted via Care Opinion (Ramsey et al., 2019). The single-site hospital provided predominantly acute services and adopted a centralised model to patient experience encompassing PALS and complaints managed by the head of patient experience. However, the communications team were responsible for online feedback. This responsibility was largely held with a junior member of staff who copied and pasted the same response, and managed by the communications manager.

> While patient experience held responsibility for all other forms of patient feedback, when asked about online feedback specifically, I was sent to the communications

> office. The teams were separate in personnel, physical location and remit. The rationale for this shift in responsibility was the nature of the audience – it could be viewed by anybody. Protecting organisational reputation was the core focus of communications staff, fuelled by scars of 'the media getting a hold of things' in the past. My interview with the communications manager was disrupted as they took "urgent" calls from senior management to discuss keeping a current issue out of the spotlight. This was in contrast to the underlying premise of the patient experience teams' efforts – which on the surface at least, was to understand, restore trust and learn from patient experiences (despite a frontline staff member saying "half of the action plans are crap, and we're only implementing half of those crap actions"). Patient experience were peripherally involved in online feedback, as an alternative (discrete, identifiable and internal) audience to direct patients to, where communications staff felt that a follow-up conversation was necessary.
>
> [Site B, field note]

At the end of fieldwork over 1190 patient feedback narratives had been posted via Care Opinion regarding the organisation, which had been read more than 1,123,500 times, and most received the same generic response. There were no active users registered on Care Opinion as Communications staff responded via NHS.UK. All positive feedback was given slight variants of the response:

> Hello
> Thank you for taking the time to leave feedback about your recent experience at [X] Hospital. We are delighted to hear that you have had a positive experience. We will pass on these comments to the relevant staff.
>
> Kind regards
> [X] Hospital.

Similarly, all negative stories were responded to with variants of the response:

> Hello
> We are sorry to hear about this. Please contact our Patient Advice and Complaints Team on [XXXXXX] or email at [XXX]@nhs.net and a member of their team will look into this for you.
>
> Kind regards
> [X] Hospital.

Site C: Transparent, conversational responder

Site C provided 'transparent, conversational' responses via Care Opinion (Ramsey et al., 2019). As a mental health service provider, the Trust also delivered intellectual disability, community health care and secure mental health services. They had a formally designated patient involvement and experience team incorporating volunteering. The team worked separately to PALS and complaints, but closely with other teams including involvement champions, quality improvement and the board of governors. Those responding to feedback included staff working within the central patient involvement and experience team, but also, clinical and non-clinical staff distributed widely across the organisation.

> Each member of the involvement team appeared aligned in their views and on a "mission" to spread the word about involving and learning from patients, encouraging anyone and everyone – at any level of the organisation to take ownership of feedback, and to take it seriously. Informal relationships were key. The team helped to get over the "too busy to improve" attitude by providing middle management and frontline staff with permission for "headspace" (dedicated time) and the facilities of physical space (purpose built centres, vast conference rooms, intimate meeting spaces etc.) to think about feedback with intention, what it meant and how it was going to inform improvement. The team met regularly with frontline staff, volunteers and/or senior management including the chief executive to discuss plans to move forward. There was a friendly, open atmosphere in which criticism was welcome throughout the hierarchy. The focus was on teamwork and reflection. It was wrought with challenges. It was messy. It was tedious. It was time consuming. It sometimes meant working in spite of, rather than according to external pressures (e.g. regulators, commissioners, policy) – "if you can't break the rules, bend them". But it was deemed culturally important and their duty as caring professionals. The way they did things in the Trust translated to the way they aimed to engage with patients online.
>
> [Site C, field note]

At the end of fieldwork over 6500 patient narratives had been posted via Care Opinion regarding the organisation, which had been read more than 1,787,900 times, and received over 7500 staff responses. A total of 210 changes resulting from feedback had been registered, alongside 180 planned changes. Almost all feedback was given a bespoke response from the 890 active Care Opinion users often by staff or teams closely associated with the care being discussed. Most responders had a profile identifying their name, role, photograph and/or personal contact details. Responses were generally free-text; however, some were hand-drawn or used images, enabling those with communication difficulties to interpret them more easily. Some feedback received multiple responses, such as the example responses given to feedback below:

> What a marvellous story to receive. I hope you continue to be well and in time can get more involved in giving something back.
>
> [Response 1, Communications manager]

> It would be hard for us to describe the extent to which your story has been shared. It has been viewed online over 2,000 times, but this is only the half of it... thousands of our staff have heard your words and they have formed their very first impressions of the kind of care we expect them to provide. Your story is also part of presentations we deliver to staff once in their roles, as a perfect reminder of what we're all aiming for... We had one of our favourite lines... hand painted on the wall of our headquarters.
>
> [Response 2, Patient experience team]

> For many years now, your story has been shared with every single person that comes to work for us. Astonishing + moving.
>
> [Response 3, Executive director]

> We hope you continued in your recovery well beyond the time you spent with us and we are so grateful that you took the time to write to our staff to share your thanks and describe how much of an impact they'd had in your life. Equally, you had a big impact on us.
>
> [Response 4, Involvement team]

Context regarding how the dramaturgical concepts relate to overall approaches to patient experience and online feedback specifically is provided in Table 2.

Preparedness to perform

Backstage, organisations showed varying levels of preparedness to 'perform' responses to patients online. At site A, patient-informed improvement lacked organisational priority which was interlinked with resource and staffing issues, and lead to a preference for discrete interactions, such as private telephone calls or engaging with survey data. In contrast, patient-informed improvement was central to the wider ethos at site C, translating into an organisational expectation of all staff to engage with patients wherever they chose to provide their feedback. Uniquely, site C also aimed to ensure that all patient experience information was made publicly available. Underpinning this, was a decade of challenging work and determination from key members of the central team. Actors tirelessly worked to gain support for their vision throughout the hierarchy. This vision was built on the assumption that being prepared to openly discuss issues raised by patients online and also to work backstage to improve services as a result was a demonstration of their organisational values. Our observations suggested that preparedness to perform was complex and intertwined with a range of factors. This included how local networks of actors were setup (i.e. who became involved and excluded and the capacity for team working), the roles and responsibilities of those involved (i.e. whether responsibilities sat with communications staff, patient experience staff and/or frontline teams) and the practices in which they were embedded (i.e. the extent patient feedback was listened to, learnt from and valued), all of which were encompassed within the wider organisational culture surrounding patient experience.

> Staff were available to patients directly, but not publically. A walk-up desk was located close to the main hospital reception. The office was run similarly to a call centre. Staff openly expressed frustrations of feeling undervalued within the organisation to me and each other. The manager referred to his team as the "unsung heroes". Engaging with online patient feedback was something that felt too ambitious. They had to get the basics right first. There was neither local drive, nor top-down pressure to engage with it.
>
> [Site A, field note]

Crafting the script or directing the stage

We observed that preparedness to engage openly with patients online helped to inform the extent staff were organisationally supported with the tools they needed to do so. At each site, a limited number of stakeholders determined organisational response types they were willing to perform online, providing insights into sociocultural contexts and behind-the-scenes activity. While theo-

TABLE 2 Dramaturgical concepts.

	Site A: Non-responder (Ramsey et al., 2019)	Site B: Generic responder (Ramsey et al., 2019)	Site C: Transparent, conversational responder (Ramsey et al., 2019)
Performance	Largely unwilling to respond to online patient feedback, yet some sporadic engagement.	Responses limited to two generic narratives, disguising reluctance to perform.	Responding conversationally formed part of a wider cultural mission for transparency.
Scripting	Staff generally ignored online feedback, yet provided sporadic generic responses. There were few opportunities for others within the central PALS and complaints team to challenge the approach despite disagreement. However, a new chief nurse evaluated the overall patient experience approach during fieldwork, but it was too early to determine if this had any implications for how online feedback was engaged with.	Communications staff created and provided generic responses, with a general organisational unawareness of online feedback as a phenomenon, aside from the patient experience team who were loosely informed but had limited involvement.	The Involvement team created and disseminated online feedback guidelines to multidisciplinary clinical and non-clinical staff across the outlining how online conversation with patients should be approached. This ranged from frontline teams to the chief executive and board of governors. The guidelines were used to challenge staff who did not conform.
Setting	The few part-time PALS and complaints staff were located within a confined front-of-house office to answer patient calls and input data, with a separate room and walk-up desk for private patient interactions. Staff later moved sites to an open-plan office with shared facilities with others non-clinical staff across the organisation, no longer accommodating private patient interactions.	Patient experience staff were located within one of three areas: 1. A small office housing PALS staff near the hospital entrance with a hatch for patient interactions 2. A corridor of patient experience team offices 3. A small open-plan office of communications staff. There were also nearby meeting rooms for formal multidisciplinary discussion.	The patient experience and involvement team offices were located alongside other senior staff. Informal discussions were held within two purpose-built involvement centres. Formal multidisciplinary meetings were held across the dispersed site, including large open-plan meeting rooms and a conference centre with facilities for presentations and breakout discussion.
Staging	Most patient interactions were held directly via the telephone, email or letter. If staff had the time, patients who gave their feedback online were redirected to contact PALS directly.	Communications staff purposefully redirected patients to PALS due to capacity concerns and apprehensions surrounding public engagement.	Staff across the organisation were encouraged to meet patients where they wished to communicate, including online. The Trust also crafted their own website making most patient feedback publicly available.

retically, there was an element of choice from individual staff to improvise, their responding style was largely predetermined by organisational 'scripts' or detailed 'stage directions'. Standardised scripts used at site B, and occasionally at site A, appeared to masquerade organisational reluctance to engage. Staff, including the communications manager at site B, suggested that repeatedly re-enacting the same 'non-performance' was a product of tensions between the reputational risks of responding generically using contrived dialogue, and dangers associated with responding publicly to patients more authentically. The generic approach was also used for arguably more legitimate purposes, including backstage efficiency and limited capacity.

> We don't want to be responding publicly... we do invite them to contact the PALS team who can discuss it and investigate it properly... I don't think that type of contact is appropriate really, going into detail for everybody to see.
>
> [Site A, PALS staff]

Conversely, site C staff were guided by 'stage directions', purposefully crafted to encourage conversational responding, giving actors the most freedom to improvise both front and backstage. Paradoxically, extensive support was required to enable responders to feel comfortable in using unscripted discourse.

> Organisational Responsibility for Care Opinion:
> • Monitor, track and respond to ALL stories posted
> • Ensure teams are replying to stories within the timescales set out...
> • Promote ownership and responsiveness
> • ... Response style: Conversational and easy to understand for a public audience.
>
> [Site C, Care Opinion guidelines]

Frontline staff were not necessarily 'born-performers', yet the team worked to prepare, disseminate and ensure their approach to responding to patients online was embraced and culturally rooted backstage. Staff felt increasingly comfortable exposing their organisation and the honest opinions of patients publicly, as they were busy working to improve. They were also contented that most feedback received timely public responses, which were largely personable, compassionate and transparent, aligning with their professional duty as caring professionals. Documentation also formed the bases for staff to challenge others who did not conform to the organisational style set out.

> One of the things we've learnt in ten years is don't be afraid to challenge a poor response... an informal response is what we're looking for... some empathy for the person who has left it. Not everybody is comfortable with a conversational style... it takes a bit of practice.
>
> [Site C, Patient experience staff]

Performance prioritisation

Responding to online patient feedback was one of many performances frontline staff managed day-to-day, alongside their roles as caring, efficient and competent professionals. Using power as a strategy of influence, frontline staff at site C were aware that service managers and the board were front row spectators of online interactions with patients, creating both top-down pressures and local-level expectations to engage in improvement work both backstage and publicly, and nudging hesitant actors onstage.

> Postings with no responses will be followed up by the involvement team or the communications team who will forward a reminder to general managers including heads of service (if necessary). The Trust board discusses Care Opinion response times reported in the monthly patient voice report.
>
> [Site C, Care Opinion guidelines]

Engagement with Care Opinion was not driven by senior staff at sites A or B, and was, therefore, not considered culturally important in comparison to other clinical priorities, leading to a general unawareness of the platform. As a strategy to limit the demand to respond to patient feedback online at site B, staff were encouraged to absorb patient feedback personally on the ward or via PALS, with the ultimate goal of avoiding formal complaints being raised against the organisation, which often brought larger audiences of more senior staff.

Invisible work

Contrary to site C's efforts to make feedback visible, our observations suggested that sites A and B preferred the invisibility of more traditional feedback methods. Site A staff were keen to remain in the shadows where possible, turning a blind eye to what was perceived as the 'booing online crowds'. However, those at site B were intrigued to peer onstage and understand how the audience were receiving their services while taking comfort in invisibility. The team took the stance that all feedback was there to be learnt from, but they lacked the capacity and inclination to publicly engage. Some were satisfied that their backstage invisible work was improving services for the most part, and was not something they sought public recognition for. However, staff were also conscious that some feedback collection efforts had minimal influence on organisational learning, contributing to a discomfort of public exposure.

> I seriously don't think our Trust could carry that weight... We'd need dedicated people... It's not just about putting that information up there it's about writing it in the right tone, liaising with the teams to ensure that that work has been done. There are lots of checks and balances that would need to be in place before you could publicly put that statement up saying... "We have incorporated changes and now we can commit that this will not happen to another patient".
>
> [Site B, Communications manager]

Cast list

Our observations suggested that the extent organisations were prepared to 'perform' online helped to inform the social network of actors involved. We have conceptualised these networks as 'cast lists'. Site A's cast list was diffused and confused, yet sites B and C had actors fulfiling similar roles. This included 'performance directors' ultimately responsible for creative decisions and managing administration rights of the production, protagonist(s) and scout(s) of talent. One key variable was the centralised versus distributed approach, with a team of over 890 staff able to monitor and respond to online patient feedback at site C, in comparison to a maximum of two at sites A and B. Other variables included the extent the cast had a range of underpinning disciplinary backgrounds, the strength of working relationships between actors involved and their

approach to individually identifying themselves when responding online. At site C, where staff were prepared to perform, they were also better equipped with a wider, varied and engaged social network with strong working relationships.

> The communications manager explained how their junior staff member copied and pasted the same response to all patient feedback posted online regarding the organisation - "you could be forgiven for thinking it was a computer that responded." They did not consider this gold standard, but felt that without a wider team being involved, providing bespoke responses was not something they could realistically do.
>
> [Site B, field note]

Protagonist(s)

Site B had two key actors, whose roles and responsibilities were held exclusively within the communications team, albeit anonymously to the online audience. Suggestions to include patient experience representatives were discounted due to reluctance to place unprepared actors onstage. This was thought to require a designated creative team to craft and embed an adequate script backstage.

> We're under-resourced, we don't have anyone who has the time or skills to do that [personalise responses]... If we were to revisit and really think about what we're doing and how that fits in with branding and reputation, it would be either our team doing that, or our team advising and maybe running masterclasses with the patient experience team around how to write engaging and conversational content.
>
> [Site B, Communications manager]

Similarly, frontline staff were not considered to take a leading role, despite arguably being best-suited. Contrastingly, at site C, responsibilities for directing online performances were shared widely amongst keen individuals who were continually identified across the organisation, resulting in the largest number of staff listening and responding on Care Opinion in England. Cast list expansion was described as a challenge initially, particularly for those in roles heavily invested in reputation.

> Originally, I was against using online patient feedback as part of my job is reputational protection and I worried that it would be a case of washing your dirty linen in public. For that reason, feedback responses were limited to three people... This has grown steadily as we have learnt the value.
>
> [Site C, Communications manager]

Newly appointed staff were reassured that experienced colleagues would be on the wings to give cues where necessary, and could cover stars of the show in their absence.

> Sometimes managers or staff don't respond at all. And despite the reminders they haven't done it, and I just think it is more important for them to get a response, so then I will get involved... then there's something physical that other people can see.
>
> [Site C, General manager]

Who gets to wear the mask?

While patients remained anonymous on Care Opinion, staff were able to choose the extent they identified themselves. Nevertheless, the approach to anonymity tended to be organisationally determined. Site A and B staff were keen to preserve anonymity by signing responses off ambiguously from the hospital, with apprehensions regarding power imbalances being subverted in favour of anonymous patients. In contrast, site C encouraged staff to identify themselves individually, and empathise with patient preferences. There was belief that enabling patients to find comfort behind a masked identity via an independent feedback platform facilitated an open and honest conversation. This was reflected upon by a patient who felt that anonymity meant that issues could be dealt with more objectively, appearing particularly important within the mental health setting. This was articulated at an event with over 100 senior staff attendees.

> Anonymity makes feedback a less scary and risky thing to do... What if they take my services away if I speak out? If they're horrible to me afterwards? If they see my anger as poor mental health, rather than being quite frankly fed up with your service? Care Opinion is a step removed... I communicate with people behind-the-scenes... we can share our vision... invite each other to re-see these systems, organisation and structures, as means to serve our shared purposes. We want the same thing really.
>
> [Site C, Online patient feedback provider]

Site C staff saw the benefits in not only 'performing' responses to patients online, but also becoming captive audience members of patient performances. By welcoming patients on stage, their voices were amplified, increasing the opportunities for their feedback to be learnt from backstage. This was in contrast to concerns that 'unknown' individuals could be arriving with ulterior motives such as personal attacks directed at individual staff and the organisation. Our observations suggested that anonymity often meant that not only was the online frontstage disengaged with, but backstage activity was also evaded as it was perceived that without identifiable information, feedback could not be learnt from.

> Online, you don't know who you're dealing with... they put information on there for everyone to see that we can't deny or respond to appropriately... you've got a wide audience out there who might be using it for all different reasons... We couldn't ask any questions to get more information and we wouldn't know who this specific patient was to get to the bottom of what actually happened, or when.
>
> [Site A, Patient experience staff]

Some assumed that rather than expecting a response, patients' motive was anonymously, publicly and vociferously 'rant[ing]' in a directionless manner.

> We wouldn't go online and say "this should have happened"... It wouldn't be on a public forum. That's the best way to do it. Because actually, some people just want a rant.
>
> [Site A, Head of patient experience]

However, some did have contrasting views to their colleagues, expressing compassion for those who offered insights into often emotive, personal healthcare experiences. The importance of

anonymity from a patient perspective was recognised by a site A staff member who, as an individual, felt powerless to enact upon such beliefs due to inflexibility of the defensive organisational script.

> It takes a lot for someone to complain and quite often they want to remain anonymous. Sometimes they think... giving feedback will impact on their care going forward so they want to speak about it, but they don't want to give specific details, and you can sort of understand... it's a shame... they just get a generic response but unfortunately that's all that we can do.
>
> [Site A, PALS staff]

Cultural disruption: Expression or exposure

The visibility of online feedback was perceived to be potentially disruptive of organisational culture, both positively and negatively. Some had apprehensions regarding threats posed to reputation as audiences such as senior management, regulators and commissioners could view how patients were experiences their services, while others were keen to culturally express to the same audiences via novel windows of opportunity.

> The central team met regularly with others across the organisation and throughout the hierarchy to share their views on involvement and engagement. There was a non-risk-averse attitude towards online exposure which staff were keen to share. A patient experience staff member repeatedly said – "if you're not hearing negative feedback, it's because it's being said elsewhere." as a way of persuading frontline staff to reframe their thinking, and view it as a golden opportunity to improve.
>
> [Site C, field note]

Windows of opportunity

At site C, Care Opinion was viewed as on opportunity to convey curiosity and sincerely attend to patient feedback, considered both an intervention for mental health patients within itself, and provide backstage improvement opportunities, evidenced by over 210 tangible changes resulting from online feedback, alongside 180 planned changes, and a host of others difficult to measure (e.g. changes in staff mind-set or cultural shifts).

> It's one of the strongest forms of governance... You can think, "Well I've heard this from the staff and I'm hearing this from the patients. What is this all really telling me?".
>
> [Site C, Service improvement facilitator]

Staff were mindful of how public responses were representative of organisational values to a wide range of potential audiences and used stage directions to help unite responses with improvement activity behind-the-scenes.

> There's a total and upfront honesty about it. Somebody has said this and we're going to have it published from our organisation and we're going to respond to it and the

> whole world and their dog can see what people are saying, how they are feeling and how they are experiencing our services... that's such a healthy thing.
>
> [Site C, Patient experience manager]

The public nature enabled feedback loops to be visibly closed in real-time, and provided wider benefits such as: allowing staff to learn from other experienced responders, helping overcome modesty surrounding disseminating best practice and evidencing backstage organisational learning to those within and outside of the organisation.

> Two years, and nothing really happened. But when the story was placed on Care Opinion we were able to resolve it in 6 weeks.
>
> [Site C, Involvement and experience officer]

Publicising negative feedback helped known issues to be emphasised to management, meaning that staff could gain leverage with key stakeholders removed from the frontline, yet with the authority and autonomy to deliver change. This sometimes meant placing issues under the spotlight, before sitting back and becoming a part of the audience to watch for an organisational response.

> Be genuine, and if I can't do something I would say that I can't do it. Even if that might frighten people within the organisation. If it's the truth it's the truth. And then that may be helpful in a roundabout way to get some action.
>
> [Site C, Quality improvement staff]

However, others felt less comfortable publicising backstage difficulties. Some referred to organisational infrastructure placing boundaries on improvement, meaning they felt compelled to compose a public façade to disguise private despair.

> We have feedback pretty much consistently that patients would prefer not to have so many bank staff. We always give the same responses, "We have regular bank staff and we try and train them". But the feedback never seems to change. The common-sense approach would be to employ more staff and less bank staff, but because of the structures and systems, we just can't do it. It feels frustrating.
>
> [Site C, Service improvement staff]

Reputational threat

For some, publicising patient feedback to a wide and unknown audience posed potential threats to reputation. For instance, site B staff compared communicating with patients on a one-to-one basis with public alternatives, such as engaging with Care Opinion.

> The Facebook reviews are done pretty well... quite generic, but I feel fine giving those responses because they probably won't see it as generic... My concern is when someone is making a judgement about our Trust... looking at a list of reviews and

> seeing that we give out those generic responses and how that would impact their perception.
>
> [Site B, Communications manager]

Deliberate staging techniques aimed to limit potential reputational damage. Staff referred to making concerns raised via traditional feedback methods 'go away' via discrete behind-the-scenes discussions with staff and one-to-one patient interactions. Strategically excluding unwelcome spectators allowed interactions that could risk spoiling their performance to be conducted out of sight. For example, at site A, perceptions that staff characters lacked authenticity ultimately caused team stage fright and led to senior staff encouraging the team to ignore those who anonymously heckled online. At site B, staff felt that while under resource constraints, the more meaningful goal of backstage improvement work should be prioritised over communicating activities to unknown individuals online. While this was perceived to effectively minimise reputational risk, it was met by a disgruntled viewing audience who often declined invitations to contact staff in other ways. Conversely, performing to a crowd was part of site C's wider proactive mission for transparency and provided a means to purposefully use patient feedback for organisational improvement and enable ongoing patient involvement. Staff considered the real threat to reputation differently. Here, it was not the sentiment of feedback itself, but how the organisation responded and reframed the conversation that was important to any viewing audience member.

> When parents say "why are you stopping our Tuesday group?" we looked and pushed back with... "this is great, we would really like volunteers to help to run this group, would you like to get involved?" so it was sort of encouraging that participation as well to turn things around.
>
> [Site C, General Manager]

However, concerns remained at site C where online responses misaligned with perceived organisational culture. This included dismissing the focus on transparency by moving the conversation offline, providing knee-jerk responses to appear responsive yet neglecting opportunities to improve and making ambiguous suggestions that changes had been made, yet changes being made clear.

DISCUSSION

Our re-analysis of ethnographic data using Goffman's ideas of dramaturgy (1959) identified key implications of placing patient feedback online, most significantly, that the way organisations approach 'frontstage' responding reflects 'backstage' improvement activity. The analysis emphasised three key elements that need to be in place for NHS Trusts to embrace the preformative nature of online patient feedback. Firstly, being prepared to perform, secondly, setting the casting net wide to engage a multidisciplinary network of actors and finally, viewing online patient interactions as valuable opportunities to culturally express to a wide, varied and unknown(able) audience. Each of these concepts are explored in detail and considered in relation to existing literature.

Preparedness to perform

Placing patient feedback in the public domain commanded additional layers of complexity, transparency and performativity of staff, but also extended opportunities for improvement work,

when compared to more traditional patient feedback sources requiring only discrete management backstage (e.g. survey data). Building on earlier findings highlighting that 'transparent, conversational' response types were preferable to patients and indicative of organisational culture (Baines et al., 2018; Ramsey et al., 2019), they were also often the most meaningful responses for organisational learning backstage, providing a glimpse behind the organisational curtain. Therefore, the extent to which organisations are willing to perform transparent and conversational responses to patient feedback posted online could help to indicate not only the structural and social contexts in which staff are working, but perhaps the wider organisational culture surrounding patient experience and the extent to which organisations listen and learn. Conversely, those ignoring or providing generic responses to online feedback may reflect issues with capacity and resource and/or an organisational hesitance to embrace transparency and patient-centred improvement.

Nevertheless, embracing a transparent and conversational way of responding to online patient feedback tended to be daunting for staff. Preferences for data that felt 'safe' (Montgomery et al., 2020) often led to online patient feedback being ignored or responded to generically. Importantly, responding conversationally was not something that staff felt able to enact independently, demonstrating how this was unfamiliar and uncomfortable territory. Much work within the wider context of healthcare was supported by formalised policy and procedure, and could be conducted privately or in the comfort of a small identifiable audience, whereas the public domain extended 'gaze' (Montgomery et al., 2022). For that reason, individual preformative trajectories were often predetermined by prescribed 'scripts'. However, detailed 'stage directions', alongside support from experienced actors, enabled initial stage fright to be overcome, and allowed staff to feel that responding authentically to patients online was culturally endorsed. This supports the argument from Goodwin (2019) which suggested that cultural change is difficult to achieve, however, we should aim to influence the 'circumstances, practices, policies and priorities that can be changed' as they anchor culture in place. While individuals often had their own, sometimes divergent, opinions regarding how the organisation should approach responding, it was clear they felt unable to challenge the status quo of the habitual approach, often developed and imposed by a few individuals, aligning with early sociological ideology (Berger Peter & Luckmann, 1966). Rather, at site C, this required work from the central team to gain a gradually increased in buy-in throughout the hierarchy. This aligns with findings from Martin et al. (2019) who identified the need for additional 'cultural engineering' alongside amendments to policy, to facilitate change.

Setting the casting net wide among multidisciplinary staff

A distinct approach to responding to online patient feedback was adopted at site C, with a view that bigger was better in terms of the participation of many staff with varied disciplinary backgrounds, the size of their audiences and the length and depth of performances they were willing to provide. This was in comparison to centralised approaches delivered by restrictive teams of staff at site A and B, often limited to a singular discipline, with preferences for as few audience members as possible and performances to be brief, if at all. Collaboratively engaging multidisciplinary staff across all levels of the organisation has recently been argued to enhance 'team capital' (Bourdieu, 1977; Montgomery et al., 2020). Conversely, failure to engage staff may lead to reduced opportunities to learn and magnify existing patient-staff power imbalances online, whereas engaging in open communication and evidencing how unsolicited feedback from anonymous patients can inform improvement may encourage equal partnerships and help to redress power imbalances (Smits et al., 2020; Speed et al., 2016).

Embracing online patient interactions as valuable opportunities to culturally express

Not only were staff experiencing the benefits and challenges of collecting, reporting and acting upon patient feedback, but also the potential of public interactions to disrupt wider organisational culture. This was interpreted as a pervasive threat to organisational reputation for some, yet provided windows of opportunity for others. Where improvisation in responding was embraced, staff were individually empowered to overcome fears of judgement, take ownership and enter the 'brave new world', providing that responses remained within the organisational boundaries set out. It was important to accept that things inevitably went wrong in healthcare, rid of blame culture and meaningfully engage with patients to facilitate organisational learning, as called for by the Francis report (2013). This involved changing the perception of transparency posing a threat to reputation, into opportunities to culturally express, becoming increasingly responsive and more effective at improvement. In support of this, Schlesinger et al. (2015) suggested that feedback collection efforts were only worth the administrative burden where adequate mechanisms are in place to translate concerns for reputation into increased responsiveness and effectiveness. Similarly, Dixon-Woods et al. (2014) described how some organisations engage in 'problem-sensing' behaviours, involving actively seeking organisational system weaknesses, and using multiple data sources including 'soft-intelligence' to actively listen to stakeholders and enable fresh, penetrating insights to drive improvement. This can be seen at site C, where the initial uneasiness surrounding genuinely listening and responding to patient feedback regardless of the level of criticality was embraced culturally. This became a way of exploring new ways of improving services, developing reflective practices and showcasing a culture to be proud of. It also aligns with the findings from Mazanderani et al. (2021) which suggested that the rationale for online feedback provision was often considered an enactment of care in and of itself, conceptualised as a way of 'caring for care', with the potential to inform improvements in their own care, that of others and/or benefit healthcare providers and the NHS more widely. In comparison, sites A and B engaged in 'comfort-seeking behaviours', which were defined as tendencies to seek assurances that all is well with staff collecting much data but little intelligence. Dixon-Woods et al. (2014) further suggested that being preoccupied with demonstrating compliance with external expectations may risk serious blind spots arising, particularly when limited means of data collection are used and negative feedback is dismissed as 'whining' or disruptive behaviours. This was demonstrated where online feedback was trivialised as a means for patients to publicly 'rant' meaninglessly. Therefore, actively seeking, engaging with and learning from patients who provide their feedback online may help to develop and publicly demonstrate a healthy patient experience culture.

Limitations

This study has three key methodological limitations. Firstly, while researchers did all that they could to emphasise confidentiality and make participation as safe as possible, it cannot be determined if recruitment secured a breadth of views or complete accounts from those who consented. We struggled to recruit certain staff of interest, such as PALS and complaints staff at site C, the chief nurse at site A and a wider variety of frontline staff at all sites. We thought that this was due to the pressures staff were facing and their limited capacity to engage in something additional to their job. Secondly, while fieldwork duration lasted a year and aimed to provide the

historical context where necessary, the findings describe a relatively short period of time and are ultimately situational. Finally, the early effects of the COVID-19 global pandemic cut fieldwork short, meaning that two planned observations were cancelled and potential interviewees stopped being pursued. However, the observations were of meetings previously observed multiple times, and were thought to have minimal impact on the study.

CONCLUSIONS

Our findings suggest that organisations must be culturally prepared to engage with patients transparently and conversationally online, and this may require a multidisciplinary network of actors working both back and front stage. Equally, the visibility of patient-staff interactions to a wide, varied and unknown(able) audience has the potential to be culturally disruptive, dichotomously invoking either apprehensions of reputational threat or providing windows of opportunity. Therefore, we conceptualise that online feedback may provide a glimpse behind the organisational curtain and could be viewed as a cultural enactment of patient-centred care. Ignoring or providing generic responses to online patient feedback may reflect not only a lack of engagement with online patient feedback specifically but a wider backstage hesitance to embrace transparency, patient-centred improvement and/or issues with capacity and resource. Conversely, engaging openly with patients in a public manner may indicate that organisations are better able to centralise patient-informed improvement as part of a wider ethos. Despite the seemingly reciprocal relationship between culture and online engagement with patient feedback, manipulation of how organisations respond to patients online is unlikely to be enough to meaningfully shift backstage culture alone. Front stage engagement may also exist in the absence of a patient-centred culture. Furthermore, individuals and teams may not feel able to embrace online patient feedback alone, but may require organisational and/or national support. For example, organisations could assign dedicated time and resources for multidisciplinary staff to autonomously consider patient feedback intentionally, with an aim to gradually shift organisational culture and increase the extent to which staff across disciplines become invested in transparently improving patient experience.

AUTHOR CONTRIBUTIONS

Lauren Ramsey: Conceptualization; Supporting, Data curation; Lead, Formal analysis; Lead, Investigation; Lead, Methodology; Equal, Project administration; Lead, Resources; Equal, Software; Equal, Validation; Lead, Writing – original draft; Lead, Writing – review & editing; Lead, **Jane O'Hara**: Conceptualization; Supporting, Formal analysis; Supporting, Funding acquisition; Lead, Methodology; Supporting, Supervision; Lead, Writing – review & editing; Supporting, **Rebecca Lawton**: Conceptualization; Supporting, Formal analysis; Supporting, Funding acquisition; Supporting, Methodology; Supporting, Supervision; Supporting, Writing – review & editing; Supporting, **Laura Sheard**: Conceptualization; Lead, Formal analysis; Supporting, Funding acquisition; Supporting, Methodology; Lead, Supervision; Equal, Writing – review & editing; Supporting.

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DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request.

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REFERENCES

Allen, D., Braithwaite, J., Sandall, J., & Waring, J. (2016). Towards a sociology of healthcare safety and quality. *Sociology of Health & Illness*, *38*(2), 181–197. https://doi.org/10.1111/1467-9566.12390

Austin, J. L. (1962). *How to do things with words*. Harvard University Press.

Baines, R., Donovan, J., Regan de Bere, S., Archer, J., & Jones, R. (2018). Responding effectively to adult mental health patient feedback in an online environment: A coproduced framework. *Health Expectations*, *21*(5), 887–898. https://doi.org/10.1111/hex.12682

Berger Peter, L., & Luckmann, T. (1966). The social construction of reality. A treatise in the sociology of knowledge.

Bourdieu, P. (1977). *Outline of a theory of practice*. Cambridge University Press.

Button, G., & Sharrock, W. (1998). The organizational accountability of technological work. *Social Studies of Science*, *28*(1), 73–102. https://doi.org/10.1177/030631298028001003

Coffey, A., & Atkinson, P. (1996). *Making sense of qualitative data: Complementary research strategies*. Sage Publications, Inc.

Dixon-Woods, M., Baker, R., Charles, K., Dawson, J., Jerzembek, G., Martin, G., West, M., McKee, L., Minion, J., Ozieranski, P., Willars, J., & Wilkie, P. (2014). Culture and behaviour in the English National Health Service: Overview of lessons from a large multimethod study. *BMJ Quality and Safety*, *23*(2), 106–115. https://doi.org/10.1136/bmjqs-2013-001947

Donetto, S., Desai, A., & Zoccatelli, G. (2019). Organisational strategies and practices through which patient experience data can be linked to care improvements in acute NHS hospital trusts: An ethnographic study. Health Services and Delivery Research No 7.34. NIHR Journals Library.

Ellingson, L. L. (2003). Interdisciplinary health care teamwork in the clinic backstage. *Journal of Applied Communication Research*, *31*(2), 93–117. https://doi.org/10.1080/0090988032000064579

Flott, K. M., Graham, C., Darzi, A., & Mayer, E. (2016). Can we use patient-reported feedback to drive change? The challenges of using patient-reported feedback and how they might be addressed. *BMJ Quality & Safety*. bmjqs-2016.

Flyvbjerg, B. (2006). Five misunderstandings about case-study research. *Qualitative Inquiry*, *12*(2), 219–245. https://doi.org/10.1177/1077800405284363

Francis, R. (2013). *Report of the Mid Staffordshire NHS Foundation trust public inquiry: Executive summary* (Vol. 947). The Stationery Office.

Freeman, T., Millar, R., Mannion, R., & Davies, H. (2016). Enacting corporate governance of healthcare safety and quality: A dramaturgy of hospital boards in England. *Sociology of Health & Illness*, *38*(2), 233–251. https://doi.org/10.1111/1467-9566.12309

Garfinkel, H. (1952). *The perception of the other: A study in social order*. Havard University.

Goffman, E. (1959). Presentation of self in everyday life. *American Journal of Sociology*, *55*, 6–7.

Goffman, E. (1967). On face-work. Interaction ritual (pp. 5–45).

Goodwin, D. (2019). NHS inquiries and the problem of culture. *The Political Quarterly*, *90*(2), 202–209. https://doi.org/10.1111/1467-923x.12693

Hajer, M. A. (2005). Setting the stage: A dramaturgy of policy deliberation. *Administration & Society*, *36*(6), 624–647. https://doi.org/10.1177/0095399704270586

Hochschild, A. R. (1983). Social constructionist and positivist approaches to the sociology of emotions - Comment. *American Journal of Sociology*, *89*(2), 432–434. https://doi.org/10.1086/227874

Knoblauch, H. (2005). Focused ethnography. In *Forum qualitative sozialforschung/forum: Qualitative social research* (Vol. 6, No. 3).

Levay, C., Jonsson, J., & Huzzard, T. (2020). Quantified control in healthcare work: Suggestions for future research. *Financial Accountability and Management*, *36*(4), 461–478. https://doi.org/10.1111/faam.12242

Locock, L., Montgomery, C., Parkin, S., Chisholm, A., Bostock, J., Dopson, S., Martin, A., Gibbons, E., Graham, C., King, J., Powell, J., & Ziebland, S. (2020). How do frontline staff use patient experience data for service improvement? Findings from an ethnographic case study evaluation. *Journal of Health Services Research and Policy*, *25*(3), 151–161. https://doi.org/10.1177/1355819619888675

Marion, J. (2002). *In excess: Studies of saturated phenomena*. Fordham University Press.

Martin, G. P., Chew, S., & Dixon-Woods, M. (2019). Senior stakeholder views on policies to foster a culture of openness in the English National Health Service: A qualitative interview study. *Journal of the Royal Society of Medicine*, *112*(4), 153–159. https://doi.org/10.1177/0141076818815509

Martin, G. P., Chew, S., & Dixon-Woods, M. (2021). Why do systems for responding to concerns and complaints so often fail patients, families and healthcare staff? A qualitative study. *Social Science & Medicine*, 114375.

Martin, G. P., McKee, L., & Dixon-Woods, M. (2015). Beyond metrics? Utilizing 'soft intelligence' for healthcare quality and safety. *Social Science & Medicine*, *142*, 19–26. https://doi.org/10.1016/j.socscimed.2015.07.027

Mazanderani, F., Kirkpatrick, S. F., Ziebland, S., Locock, L., & Powell, J. (2021). Caring for care: Online feedback in the context of public healthcare services. *Social Science & Medicine*, *285*, 114280. https://doi.org/10.1016/j.socscimed.2021.114280

Montgomery, C., Parkin, S., Chisholm, A., & Locock, L. (2020). Team capital' in quality improvement teams: Findings from an ethnographic study of front-line quality improvement in the NHS. *BMJ Open Quality*, *9*(2), e000948. https://doi.org/10.1136/bmjoq-2020-000948

Montgomery, C. M., Powell, J., Mahtani, K., & Boylan, A. M. (2022). Turning the gaze: Digital patient feedback and the silent pathology of the NHS. *Sociology of Health & Illness*, *44*(2), 290–307. https://doi.org/10.1111/1467-9566.13419

Pinch, T. (2010). The invisible technologies of Goffman's sociology from the merry-go-round to the internet. *Technology and Culture*, *51*(2), 409–424. https://doi.org/10.1353/tech.0.0456

Powell, J., Atherton, H., Williams, V., Mazanderani, F., Dudhwala, F., Woolgar, S., Boylan, A. M., Fleming, J., Kirkpatrick, S., Martin, A., van Velthoven, M., de Iongh, A., Findlay, D., Locock, L., & Ziebland, S. (2019). Using online patient feedback to improve NHS services: the INQUIRE multimethod study. *Health Services and Delivery Research*, *7*(38), 1–150. https://doi.org/10.3310/hsdr07380

Ramsey, L., Lawton, R., Sheard, L., & O'Hara, J. (2022). Exploring the sociocultural contexts in which healthcare staff respond to and use online patient feedback in practice: In-depth case studies of three NHS Trusts. *Digital Health*, *8*, 20552076221129085. https://doi.org/10.1177/20552076221129085

Ramsey, L. P., Sheard, L., Lawton, R., & O'Hara, J. (2019). How do healthcare staff respond to patient experience feedback online? A typology of responses published on Care Opinion. *Patient experience Journal*, *6*(2), 42–50. https://doi.org/10.35680/2372-0247.1363

Ramsey, L. P., Sheard, L., Lawton, R., & O'Hara, J. (2023). *"Feedback, is indeed a dainty dish, to set before the Trust": Comparing and contrasting the sociocultural contexts in which online patient feedback is responded to and used across three NHS Trusts*. Manuscript submitted for publication.

Robert, G., Cornwell, J., & Black, N. (2018). Friends and family test should no longer be mandatory. https://www.bmj.com/content/360/bmj.k367.full. Accessed 10 09 19.

Schlesinger, M., Grob, R., Shaller, D., Martino, S. C., Parker, A. M., Finucane, M. L., & Rybowski, L. (2015). Taking patients' narratives about clinicians from anecdote to science. *New England Journal of Medicine*, *373*(7), 675–679. https://doi.org/10.1056/nejmsb1502361

Sheard, L., Marsh, C., O'Hara, J., Armitage, G., Wright, J., & Lawton, R. (2017). The Patient Feedback Response Framework–Understanding why UK hospital staff find it difficult to make improvements based on patient feedback: A qualitative study. *Social Science & Medicine*, *178*, 19–27. https://doi.org/10.1016/j.socscimed.2017.02.005

Smits, D. W., van Meeteren, K., Klem, M., Alsem, M., & Ketelaar, M. (2020). Designing a tool to support patient and public involvement in research projects: The Involvement Matrix. *Research Involvement and Engagement*, *6*(1), 1–7. https://doi.org/10.1186/s40900-020-00188-4

Speed, E., Davison, C., & Gunnell, C. (2016). The anonymity paradox in patient engagement: Reputation, risk and web-based public feedback. *Medical Humanities*, *42*(2), 135–140. https://doi.org/10.1136/medhum-2015-010823

The NHS Patient Safety Strategy. (2019). Safer culture, safer systems, safer patients. https://www.england.nhs.uk/wp-content/uploads/2020/08/190708_Patient_Safety_Strategy_for_website_v4.pdf. Accessed 08.08.21.

Timmermans, S., & Tavory, I. (2012). Theory construction in qualitative research: From grounded theory to abductive analysis. *Sociological Theory*, *30*(3), 167–186. https://doi.org/10.1177/0735275112457914

Tong, A., Sainsbury, P., & Craig, J. (2007). Consolidated criteria for reporting qualitative research (COREQ): A 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care*, *19*(6), 349–357. https://doi.org/10.1093/intqhc/mzm042

Waring, J. J., & Bishop, S. (2010). Water cooler" learning: Knowledge sharing at the clinical "backstage" and its contribution to patient safety. *Journal of Health organization and Management*, *24*(4), 325–342. https://doi.org/10.1108/14777261011064968

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