

**The Intelligent Board 2010**

# **Patient Experience**

# About Dr Foster

Dr Foster works with the NHS and other health and social care organisations to harness the power of information to improve services and people's wellbeing. To this end, our thought leadership programme seeks to share new thinking, provoke debate and stimulate action in transforming data into knowledge and knowledge into positive action. Our aim is that the thought leadership work we support should be as practical as it is interesting, founded both on insight into the operational realities of policy challenges and on expertise in using information to deliver change.

This edition of *The Intelligent Board* has been produced with the support of an independent reference group of experts from the NHS and associated organisations. They were not remunerated but were supported by research, analytic and production teams at Dr Foster, which also funded the printing and distribution of the report.

Dr Foster Intelligence is a joint venture between the Department of Health and Dr Foster Holdings LLP. In 2007 we were awarded the Laing & Buisson Independent Healthcare Award for Innovation and in 2008 we received the HealthInvestor Award for Outstanding Contribution to Healthcare.

Dr Foster first entered the patient experience world with the launch of our award-winning Patient Experience Tracker (PET) in 2006. PET was the first handheld, electronic feedback device available to the NHS to measure patient and staff satisfaction on a real-time basis. Since then real-time feedback has become a national priority. In 2009 we were awarded the NHS North West Patient Experience Measures contract to offer a real-time feedback solution to all its acute hospital trusts. Today, more than 120 NHS organisations are regularly using PET to improve their patients' experiences.

Dr Foster works to a code of conduct that prohibits political bias and requires it to act in the public interest. The code is monitored by the Ethics Committee, an independent body chaired by Sir Donald Irvine, chairman of Picker Institute Europe and former president of the General Medical Council.

Further information about the *Intelligent Board* surveys and board-paper review undertaken for this edition can be accessed at [www.drfooster.co.uk/patientexperience](http://www.drfooster.co.uk/patientexperience)

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# Foreword

NHS boards face a tough job in ensuring a proper focus on patients' experiences in the current climate of radical reform, changing demography and stringent efficiency demands. This *Intelligent Board* is a practical resource to help you do so, not just because it is the right thing to do and a core theme of government policy, but because it makes sense – in avoiding the resources wasted by failing to meet patients' needs, in attracting patients, in achieving good outcomes and in motivating that most crucial resource, staff.

There are undoubted challenges. Measuring patients' experiences involves a number of statistical, intellectual and practical complexities, but the research, measurement techniques and improvement know-how are now catching up with the other two dimensions of quality – clinical effectiveness and patient safety. Effective measurement is just the start. Boards also need to meet the leadership challenge of acting to shape the organisational culture, attitudes and human relationships that underpin good patient care.

The improvement opportunity is real. Even in those areas where national patient surveys show progress, such as the practical matters of waiting and mixed-sex accommodation, there remains variation. On matters that patients value most – having the information they need, being involved in their care and having trust and confidence in health professionals – little or sometimes no progress has been sustained nationally. Opportunities to improve board intelligence on these matters and deliver better experiences for patients are within reach.

What I know from my work on patient experience, first in maternity services and currently through the Point of Care programme at The King's Fund, is that visible board leadership is critically important. That is why I am delighted to chair this latest edition of *The Intelligent Board*. I am grateful to the members of my reference group and for the editorial and production support from Dr Foster Intelligence.



**Dr Jocelyn Cornwell**

Director, Point of Care Programme, The King's Fund,  
and Chair of the *Intelligent Board* 2010 reference group

**“People must always come before numbers. Individual patients and their treatment are what really matters. Statistics, benchmarks and action plans are tools not ends in themselves. They should not come before patients and their experiences.”**

**Robert Francis QC**, The Mid Staffordshire NHS Foundation Trust Inquiry<sup>1</sup>

# Key messages

## Real opportunities to improve

- Patient experience has tended to receive less attention than the other two key dimensions of quality – clinical effectiveness and patient safety – in recent years. That is now changing.
- National patient surveys reveal persistent variations in performance across the NHS, as well as areas where progress has proved elusive.
- Recent high-profile service failures have highlighted a lack of board-level focus on what patients were saying about their experiences of care.
- There are complexities and challenges, yet the work we have done to prepare this resource suggests that opportunities to improve are within reach for most boards.

## Why it matters

- The quality of patients' experiences is central to an organisation's reputation and productivity, making it a major risk-management issue – and opportunity. These risks and opportunities will not diminish even as the financial squeeze tightens.
- The ability to demonstrate excellent feedback from patients, carers and families is a very good marketing tool in a climate of increasing choice and competition.
- Shortcomings or failures, however, may lose custom from an organisation and risk its standing with commissioners. Those issues may continue to affect an organisation's reputation within local communities for a long time.
- Understanding and acting to improve patients' experiences is also core business for the NHS. It is an important motivator for staff and part of the statutory duty of quality for board members – a 'must do' and the right thing to do.

## How the Intelligent Board can help

- Use the intelligent board checklist as the basis for a discussion among board members (see p11).
- Prepare for that discussion by reviewing your patient experience intelligence; see whether it lives up to the intelligent board principles (see p9) and measures what matters to patients (see p10).
- Get insights from the sharp end; read about lessons that Sir Stephen Moss and Antony Sumara, chair and chief executive of Mid Staffordshire NHS Foundation Trust, have learned about putting patients' experiences centre stage (see p14-15).
- Test your understanding of patients' experiences in your trust (see p15) and ask yourself what else you could do to boost this awareness (see p11).
- Go to the board briefing (p16-21) for a digest of the different types of information available, their uses, a glossary of terms, a policy update, and highlights from our surveys of boards and non-executive directors.

**“We are all striving to better understand and improve patients' experiences. This Intelligent Board both holds up a mirror on our progress and points to practical ways forward.”**

**Jo Cubbon**, Chief Executive, Taunton and Somerset NHS Foundation Trust

## Signpost

<b>Good intelligence guide</b>	<b>p8-15</b>
<b>Board briefing</b>	<b>p16-21</b>

# The scope of this report

This *Intelligent Board* is targeted at provider boards and their members, executive and non-executive alike, aiming to be a source of straightforward guidance and a practical resource. It focuses on what boards can do to ensure they acquire a rounded understanding of how patients – and their families or carers – experience care or treatment. In this way, it aims to help boards fulfil their responsibility to hold their organisations to account for improving the quality and responsiveness of services, and to demonstrate this accountability to their local communities. While this report covers the importance of boards taking action on the basis of patient experience intelligence, it is not a guide on how to improve those experiences; nor does it aim to cover wider issues of patient involvement and engagement.

We have chosen to focus mainly on the acute and mental health trust sectors, where there are better foundations to build on when it comes to improving board intelligence on patients' experiences. This intelligence is at an even earlier stage of evolution within the primary and community services sector, though many of our key principles and messages will be equally relevant.

**Not just patients:** patient experience is useful shorthand (although ungrammatical). However, patients account for only a subset of the people who experience NHS-funded services. A comprehensive approach must therefore encompass the views and experiences of families and carers, as well as users of other relevant services. In this report, we have adopted the 'patient experience' shorthand for the purposes of readability, but wherever possible we have also sought to highlight the need to understand the experiences of this wider group of people.

## Commissioning for better patient experience

The commissioning landscape is changing, with responsibilities shifting to GP consortia, as well as the planned abolition of strategic health authorities and primary care trusts and the introduction of a new NHS Commissioning Board. As these changes take effect, specific roles and frameworks will emerge. But it is likely that some fundamentals will remain unchanged. For example, commissioners should still:

- Require meaningful reporting of patient experience from providers, enforced through standard contract-management processes
- Exercise their influence to bring greater consistency in the way providers measure and report on patient experience, enabling greater benchmarking and transparency
- Use patient feedback to inform commissioning decisions
- Monitor patients' experiences as they move between different services and providers
- Avoid a situation where both commissioners and providers are pursuing the same patients with similar demands for feedback.

**“Ultimate responsibility for safeguarding the quality of care provided to patients rests with the provider organisation through its board.”**

*Review of Early Warning Systems in the NHS, National Quality Board, 2010*

**“A health service that delivers the outcomes that matter most cannot only look at how well it is treating people in clinical or medical terms.”**

*Transparency in Outcomes: A Framework for the NHS, DH, 2010*

# What is patient experience?

There is no NHS-wide definition of patient experience. However, there is much jargon, inconsistent use of language and a tendency to confuse concepts that are related but distinct. Our reference group has adopted the following definition:

**Patient experience:** feedback from patients on ‘what actually happened’ in the course of receiving care or treatment, both the objective facts and their subjective views of it. The factual element is useful in comparing what people say they experienced against what an agreed care pathway or quality standard says should happen. The opinion element tells you how patients felt about their experience and helps to corroborate (or otherwise) other quality measures. Some measures that are not derived directly from patients are also used, on the basis that they relate to things known to matter to patients and their experience of care, such as single-sex wards.

## Why it matters to NHS boards

Governance in the NHS is complex, particularly in today’s tough financial climate. Boards are frequently exhorted to do more (and better) with less, and have to balance a large number of seemingly conflicting demands from both within and outside their own organisations.

Acquiring and responding to good intelligence about patients’ experiences is more than just another ‘must do’ for boards:

- It is a key risk-management issue for your organisation and its reputation, vital to fulfilling your governance responsibilities.
- The information revolution heralded by the 2010 White Paper will require far greater transparency about performance in this and other domains.
- ‘Getting it right first time’ is sound business practice and a key measure of efficiency.
- Reports of poor patient experience offer an opportunity to act on service problems early.
- There is increasing evidence of a positive association between patient experience and clinical outcomes,<sup>2</sup> and between quality and financial performance.<sup>3</sup>
- It is core to the NHS mission, and why most people turn up to work in the NHS.
- Patient experience will form a core domain in the new NHS Outcomes Framework.
- NHS board members have a statutory duty of quality, both personally and collectively. You are expected to be a key driving force for achieving continuous quality improvement across all services.
- And it is the right thing to do.

## Signpost

[Glossary of key terms](#) p19

**“Excellent patient experience is the best marketing tool you can have.”**

**Imelda Redmond**, Chief Executive, Carers UK, and Non-Executive Director, Homerton University Hospital NHS Foundation Trust

# The basics

Boards must recognise that there is no single or simple route to understanding patients' experiences. An intelligent board will draw on a wide range of sources and types of information – formal and informal, real-time and periodic, quantitative and qualitative, ad hoc and systematic. The key is to triangulate those various sources of intelligence so you can assess the reality of the situation (see p12-13 for a sample illustration showing how this can be done).

### Listen to real patients

Non-executive directors report enormous value in hearing directly from patients. Such accounts may be anecdotal but are nonetheless powerful and should never be dismissed. Many boards are finding ways to be more systematic about these kinds of feedback, whether by starting every board meeting with a patient story, having structured programmes of walkrounds or seeking specific reports from local involvement networks (LINKs, to become the local HealthWatch) or governors.

Appropriate guidance and support should be provided to help executives and non-executives gather useful insights from patients during walkrounds or ward visits. All board members should also review a sample of individual complaints and incidents regularly, as recommended by the Mid Staffordshire inquiry.

The value of this proactive approach is illustrated in a response to the *Intelligent Board* survey by a non-executive, saying: "Look at complaints; listen to patients' stories; talk to patients and staff on ward rounds and at trust events; get feedback from members, governors and voluntary organisations. You get a breadth of messages good and bad which, while a lot of it can be anecdotal, helps build up a picture of what it's really like."

### Written reports are also essential

Good intelligence is founded on systematic analysis of meaningful data, but it goes beyond simply reporting information or basic analysis. An intelligent patient experience report will seek to integrate diverse sources of information and analysis and give both context and interpretation for the board. Such interpretation and juxtaposition provide the basis for the kinds of discussion and challenge that can add real value.

Complaints are a particularly good example. An intelligent board will not accept mere accounts of the number of complaints received and dealt with in line with policy, and will instead require analysis of the substance of complaints, incidents, outcomes and any changing patterns. Even better are reports which not only relate this kind of information about complaints and incidents but also integrate near-real-time feedback in high volumes, as well as periodic analysis from systematic surveys. Even better again are reports which set patient experience alongside

**"There is nothing more powerful than hearing a patient's story face to face. I now see it as an essential stimulus to good governance."**

**Jim Potter**, Chair, Salford Royal Hospital  
NHS Foundation Trust

**"The board always asks and is never fully satisfied that we have found the best way of hearing about patient experience, but we strive to improve."**

Chair, Foundation Trust,  
Intelligent Board Survey

information about clinical effectiveness or patient safety indicators. Increasingly, board members' skill-sets need to include the ability to use and interpret clinical and statistical information.

Intelligent data gives boards a detailed yet rounded understanding, especially when combined with more anecdotal evidence. Jessica Bush, head of patient and public involvement at King's College Hospital NHS Foundation Trust, explains how this works in practice: "As well as presenting integrated data for complaints, PALS and our real-time 'How are we doing?' survey at trust, division, ward and specialty levels, our monthly patient experience report also includes themed patient comments which complement the quantitative data and 'make it real.'"

Crucially, boards must be seen to take the lead. "Patient experience is too often pigeon-holed as a nursing problem," says a former director of nursing at an acute trust. "The whole board needs to take ownership of it and send out the message to staff that it is a priority."

### Intelligent board principles

All information about quality for the board should:

- Cover locally defined priorities as well as national 'must do' requirements
- Focus on outcomes, not systems and processes
- Be available in a timely and understandable format, preferably monthly
- Be clearly and simply presented, including graphic overviews and brief commentary
- Be forward-looking, presenting trends and anticipating future issues
- Allow internal comparison between services and make use of external benchmarks
- Allow comparison between the experiences of diverse patient groups
- Cover the full extent of people's experiences during care, not just at the point of discharge, and including handovers between different organisations
- Combine quantitative data with softer, qualitative data and primary research
- Provide interpretation and analysis as well as information
- Provide a level of detail that is appropriate to the board's governance role.

### Signpost

**Examples of how to build an intelligent report on patient experience p12-13**

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**"All of these sources of information should be used together and discrepancies in the evidence explored rather than over-relying on any one."**

Non-Executive Director, Acute Trust,  
Intelligent Board Survey

# Measuring what matters

Good intelligence is about what is measured and how, not just the way it is reported. Our surveys and board-paper review (see p20-21) found no consistency in what boards use as patient experience measures, beyond nationally mandated indicators. Some equate patient satisfaction with patient experience, while, at the other extreme, some include mainstream safety or clinical matters (eg pressure ulcers).

There are nevertheless a number of robust and evidence-based frameworks<sup>4</sup> that define the factors which make most difference to patients' experiences. Each differs in purpose and coverage, yet they all point to very similar issues. We have grouped the domains that typically appear, for boards to check against their own intelligence.

### Transactional aspects of care – the 'what'

- Cleanliness
- Physical comfort, especially pain control
- Getting the right information at the right time to help patients understand what is or should be happening, participate in decisions and feel confident and in control
- Consistent, timely and coordinated care, including access, transfers and discharge.

### Relational aspects of care – the 'how'

- Being treated with respect by all staff, not least to preserve dignity and privacy
- Being treated with compassion and responsiveness to what matters to each individual
- Being treated with honesty, listened to and involved in dealing with the issue at hand, whatever it is.

### Future intelligence: beyond reporting the basics

The reporting of patient experience is in its infancy, and this report focuses on perhaps the most urgent needs, such as to improve benchmarking and overcome siloed thinking about the three domains of quality. Looking forward, intelligent boards will aspire to more sophisticated analysis:

- Analysis of variations by age, gender, ethnicity, sociodemographic group and type of condition
- Breakdowns to the level of service, team and consultant
- Breakdowns of people's experiences at every 'touchpoint' with a given service
- Analysis of experiences of handovers between services
- Baseline comparisons with patients' expectations
- Gathering data more systematically from relatives and carers
- Making better use of qualitative data and routine administrative data
- Gathering data on patients' experiences of community services and integrated health and social care services.

**“We want an NHS that meets not only our physical needs but our emotional ones too.”**

*Now I Feel Tall, DH, 2007*

**“There is no commonly defined framework of what is most important to patients. Nor is there much encouragement to NHS organisations to measure the same things using the same indicators.”**

*Key Domains of the Experience of Hospital Outpatients, Picker Institute Europe, 2010*

# Intelligent board checklist

Together with our reference group, we have put together a checklist to help assess whether your board has the right approach to using information intelligently.

In addition, board members have a personal responsibility to build up a picture of what it is really like to be a patient, so you have some context for numbers and traffic lights on a page. Non-executives we spoke to in compiling this resource talked about the importance of trusting your instinct; they advocated asking yourself whether the picture of care you see in a report actually correlates with what you hear from patients, see in services and read elsewhere, including in the local media.

## Are you showing leadership?

- Take responsibility for agreeing what you mean by patient experience.
- Set patient experience improvement priorities for your trust, based on local needs not just national requirements.
- Challenge yourselves to be forward-looking and proactive rather than retrospective and reactive.

## How intelligent are your reports and meetings?

- Plan an annual reporting cycle that covers monthly performance monitoring, as well as 'deeper dives' and discussions of how specific patient groups experience specific services.
- Invite a patient (or relative or carer) to tell their story at the start of a board meeting, thereby setting the tone.
- Look for reports which integrate multiple sources of information about your patient experience priorities, with essential context and interpretation.
- Challenge reports that tell you about improvement activity rather than performance and outcomes.
- Ask questions about how other trusts are performing.
- Look for qualitative data from a variety of sources (see the board briefing on p16-17) to be systematically coded and aggregated so as to exploit its power.

- Make sure that patient experience forms an integral component of quality reports and discussions, not an additional silo.
- Give close attention to staff feedback; engaging with staff is key to ensuring positive patient experiences.
- Be alert to any inconsistency in what you are being told about quality of care by measures of clinical effectiveness, patient safety and patient experience.

## Are you acting on intelligence received?

- Identify actions on 'ambers' and 'reds' then follow them up, and visibly reward and share the lessons from high performing areas.
- Get ahead on the information revolution agenda and be transparent. Publish analyses of patients' feedback – good and bad, and what is being done to address it – regularly and through a variety of channels to staff, patients and local communities.
- Look for evidence of the impact on patient experience from major decisions and programmes of change, against an agreed baseline.
- Ask each other how patients' experiences have shaped decisions in the past three months, and the implications.

## What have you personally done lately?

- How often do you personally visit wards or services and talk to patients, relatives and staff?
- Do you take other informal opportunities to hear what patients, local people and your non-executive colleagues say about the trust's services?
- Do you take a look at a random selection of complaints from time to time, just to get a feel for the sort of complaints coming in and how they are dealt with?
- Are there some services you provide which never seem to figure in patient experience reports? Have you asked whether there is a good reason for this?
- Do you recognise what a report is saying? Does it feel real?

# Building an intelligent report

These pages show samples from a comprehensive board report on patients' experiences, with special reference to maternity services. They are intended to illustrate the types of intelligent information that boards should be receiving.

## Extract from trust board papers

### Patient experience objectives

1. CQUIN objectives to remain at 90%+ success for next quarter.
2. **Improve involvement in decisions in underperforming specialties. All to be rated 80%+ by December.**
3. Achieve sustained improvement in feedback on pain control during 2010/11.

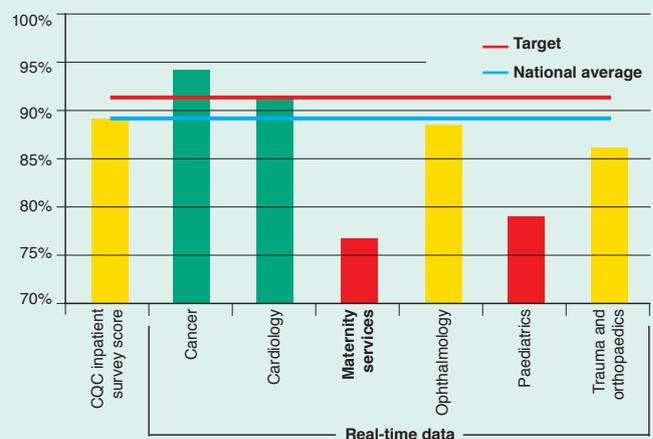
*Smart objectives set by the board are a mix of local and national priorities.*

## Tracking objective 2

*Internal benchmarking – each specialty uses handheld devices to collect patients' views, tracking national survey questions during treatment and on discharge.*

### Real-time survey

Of the 6 specialties measured on the extent to which patients were involved in decisions about their care, only 2 achieved the target last month. Maternity remains poor.



## Extract from trust board papers

### Current status

#### Achievements:

Objective 3: Focus on improving pain control is being reflected in better patient feedback. Need to ensure improvement is now sustained.

#### Areas of concern:

**Objective 2: Involvement in decision-making in maternity services – see analysis and actions.**

#### Areas to watch:

We are acquiring responsibility for community services from the local PCT. Due diligence suggests some issues around the midwife-led unit. We are undertaking further analysis and will report back.

*A summary should give a high level and contextualised digest of progress and issues. Areas of concern should trigger deeper analysis and may be a catalyst for action.*

## Deeper analysis 1

**Analysis of qualitative feedback** on experiences in maternity.  
(Themes, trends and total number of comments, Jun–Aug 2010)

Theme	Trend	Total
Inconsistent messages from midwives	↑	52
Feeling that birth preferences ignored	↑	33
Lack of continuity of care	↔	28
Info and support regarding anomaly scans	↓	31

Sources include: informal feedback, kiosks, complaints analysis, NHS Choices, focus group and real-time exit surveys

Qualitative feedback from a range of sources is coded and analysed to help provide a richer picture of experiences. The board is also invited to access a random sample of the letters, complaints, etc...

“They just weren’t interested when I said I wanted a home birth...”

“I never saw the same midwife twice...”

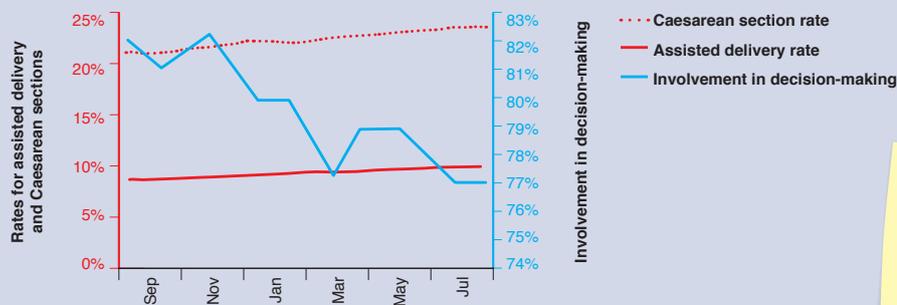
A pack of recent maternity feedback has been compiled and is available to all directors.

Click here for this month’s patient story.



## Activity and experience report

Is the poor experience data related to the increase in rates of surgical intervention in birth?



## Deeper analysis 2

Experience data should be contextualised and triangulated with clinical data.

Board members should be encouraged to interact with patients with the right focus and support.

### Extract from trust board papers

#### Some recommendations and actions

- Rapid-action team tasked with improving joint working and communications between obstetricians and midwives. Impact report due by December.
- Non-executives are invited to conduct maternity walkrounds – guidance and briefing to be given in advance.
- Additional analysis is under way on whether poor patient feedback is affecting patient flows. This will be reported at the next meeting.

# Advice from the sharp end

Here, Sir Stephen Moss and Antony Sumara, chair and chief executive of Mid Staffordshire NHS Foundation Trust, share their insights into how to put the voices of patients, their families and the local community – and the evidence of their experiences – at the very heart of the board’s agenda. This reflects a whole package of measures they have been implementing, designed to realise their shared commitment to radical improvement.

### Public board meetings

All our trust’s board meetings are held in public. The public are encouraged to participate and to evaluate the meeting. Actions taken as a result of their comments are reported in the chair’s report at the next meeting. We are transparent about the criteria for a very limited range of issues for private discussion; private items are listed on the public agenda.

### Board reports

We learned that there was an abundance of data on patient experience but too little analysis and interpretation. Board reports did not tell us a ‘story’, were lacking in qualitative information and were disconnected from other quality indicators, such as patient safety and outcomes. We have made some headway in addressing these issues but, as with many boards, this is a work in progress.

### The human impact

The human impact of what we do as a board is at the heart of our responsibilities. The board actively focuses on what it means to patients and families when our actions cause them problems, eg hospital-acquired infections. Board meetings start with a patient’s story, ideally in person (videos proved less satisfactory). This sets the tone for the meeting, and agenda items are related back to the patient’s story.

### Being on the front foot

We know that the warning signs were there at Mid Staffordshire but were ignored. We have learned that feedback from board committees must still be subject to robust interrogation at board meetings.

### Being brave

All serious incidents are discussed in the public board meeting (with appropriate attention to confidentiality). The press, who always attend, have a field day, but we have a responsibility to show how we are learning from mistakes. This is an important part of our work to restore public confidence.

**“It is important that boards are not too readily assured or reassured.”**

*The Healthy NHS Board,  
National Leadership Council, 2010*

## The role of the executive nurse

This role now focuses primarily on ensuring that high standards of care are established and delivered for patients. We have benefited from a director who has spent significant time in clinical practice and has led from the front.

## Connecting with front-line staff

We have set up a buddying system in which newly registered nurses are linked to a board member (both executive and non-executive). This is designed to encourage a better two-way understanding of how we are each contributing to patient care. The scheme is in its infancy but is already proving invaluable for non-executives, giving them insight into what is going on at the sharp end.

## The culture

A lot of our problems have been embedded in the culture of the trust for many years, and we need to deliver long-term sustainable improvement. A great deal of work is going on in this area and the board is looking at developing some 'cultural tests' to audit change over time.

## Visibility

We have learned, as a board, that we need to ensure that the picture painted by the information we receive is an accurate reflection of what it is actually like for patients. The chair, executives and increasingly non-executives regularly visit wards to talk to patients and families. Governors also undertake unannounced ward visits. A summary of all visits is entered onto a white board in the trust headquarters, and the executive lead for patient experience identifies any common themes and follows them up.

## Getting the basics right

Our board has learned that a patient's experience is influenced predominantly by how well we meet their fundamental needs. We need to be aware how long it is taking for nurses to respond to call bells, and how well we are assessing a patient's nutritional state and acting on it.

We are getting better at connecting issues relating to particular wards or particular issues with our clinical audit plan, and ensuring that action is followed up via ward visits by board members.

## Test yourself

Do you know:

- Which groups of patients are typically the most and least positive about their experiences of care? How well do you understand why?
- At which points in their encounters with your services do patients tend to report better or worse experiences?
- Which wards, departments and specialties have demonstrated the greatest improvement in patient experience over the past year? How well do you understand why?
- Which three issues are consistently implicated in poor patient experience? What action is being taken and when do you expect to see results?
- How do your services compare on patient experience with other similar services locally or nationally?
- What is the cost and risk to your trust of inadequate or poor patients' experiences?

# Intelligence types and uses

Intelligence on patient experience comes in many forms. In order to build a thorough, accurate understanding of the situation at their trust, boards should know how to make best use of the different options available.<sup>5</sup>

Quantitative methods	Qualitative methods
Self-completion postal surveys, eg national patient (and staff) surveys Interviewer-administered telephone surveys Automated telephone and SMS surveys Online ratings sites, eg: <a href="http://www.nhs.uk">www.nhs.uk</a> <a href="http://www.iwantgreatcare.org">www.iwantgreatcare.org</a> <a href="http://www.patientopinion.org.uk">www.patientopinion.org.uk</a> Online surveys (web or email) Surveys using handheld devices (on-site) Surveys on touch-screen kiosks (on-site) Surveys on bedside consoles (on-site) Exit cards and discharge surveys Routine administrative data, eg the Secondary Uses Service (SUS) and Mental Health Minimum Dataset	Formal complaints Letters and compliments Face-to-face interviews Focus groups Web-based free text comments Comment cards and suggestion boxes (on-site) Video boxes (on-site) Patient stories and diaries Mystery shopping and observation Customer journey mapping  <b>Other sources include:</b> <ul style="list-style-type: none"> <li>• Meeting minutes and reports from governors, LINks (to become Local HealthWatch), Patient Advice and Liaison Services (PALS), overview and scrutiny committees, voluntary organisations and patient groups</li> <li>• Media coverage</li> <li>• Written notes from walkrounds and ward visits</li> </ul>

**“Real-time patient feedback is your early warning system. It may not tell you precisely what the problem is but it tells you where to look sooner than any other indicator or metric.”**

Neil Bacon, Founder, iWantGreatCare

## Matching the type of intelligence to its use

Trust-level benchmarking and national trends	National patient surveys Routine administrative data
Tracking in-year progress on national and local priorities, and internal benchmarking	Local postal, phone and SMS surveys On-site surveys – handheld devices and discharge surveys Routine administrative data

Rapid identification of emerging issues	On-site surveys – handheld devices, kiosks and consoles Online ratings and free text comments Exit cards Aggregations of qualitative feedback from a variety of sources
Human insights	Complaints Patient stories Mystery shopper exercises
Deep dives	Local postal or telephone surveys Interviews and focus groups Customer journey mapping

## Questions to ask about patient experience intelligence

### How long ago was this data collected?

- Is it giving you a rapid, recent snapshot that may not be statistically representative (eg real-time feedback from handheld devices) or a statistically robust but more retrospective picture (eg national surveys)? Both are valid depending on how they are used.

### At what point in their relationship with us were people asked for this feedback?

- Is there a risk of ‘gratitude bias’ if they were asked for feedback while still on-site? Can and should this be tested through follow-up surveys?
- Does your overall patient experience intelligence combine a number of methods that cover all the key stages of patients’ journeys through the service?

### How representative is this patient experience information?

- Is it important that this information is statistically representative? It may not be if you are seeking deeper insights or the real human stories that qualitative methods can give you, or if you are looking for a rapid snapshot of the current situation from a number of sources. It may be very important if you are trying to compare the experiences of specific demographic groups or looking to make significant decisions around the allocation of resources.

## Overview

### National Patient Survey Programme annual surveys:

- Adult inpatient
- Mental health, either community or acute inpatient

### Other surveys (varying frequency, last survey date given):

- Outpatients (2010)
- Maternity services (2010)
- Emergency department (2008)
- NHS staff (annual)

The Department of Health administers a quarterly GP patient survey, though its future is unclear at the time of writing.

# 2010 policy directions

## Equity and Excellence: Liberating the NHS

The White Paper (DH, July 2010) notes that “healthcare systems are in their infancy in putting the experience of the user first” and introduces a number of commitments relevant to improving patients’ experiences. Specifically, boards should be aware of the following:

- The new NHS Commissioning Board will champion patient and carer involvement, held to account by the Secretary of State.
- Shared decision-making is seen as crucial to improving outcomes.
- An information revolution will underpin greater choice – of provider, consultant-led team, GP practice, treatment and maternity care. More nationally comparable information will be published, through quality accounts, on NHS Choices and elsewhere. Experience measures cited include: information on average and maximum waiting times; opening hours and clinic times; cancelled operations; and diverse measures of patient experience, based on feedback from patients, families and carers.
- More widespread use of patient experience surveys and real-time feedback will be encouraged. Patients will be able to rate hospitals and clinical departments according to the quality of care they receive.
- Transparency will be encouraged, not only of feedback from patients, carers and families, but also from staff.
- Hospitals will be required to be open about mistakes and always tell patients if something has gone wrong.
- The Care Quality Commission (CQC) will house a new patient champion, HealthWatch England. LINks will become the local HealthWatch, under the aegis of local authorities.

## Transparency in Outcomes: A Framework for the NHS

This consultation paper (DH, July 2010) makes patient experience one of five ‘outcome domains’ in a new NHS Outcomes Framework. It identifies shortcomings in existing arrangements for measuring patient experience, both nationally and locally, and the limited availability of standardised national data.

In the short term, the proposal is to continue to track selected questions against five patient experience themes where available from existing national surveys (as in Commissioning for Quality and Innovation, CQUIN). In the longer term, the proposal is to develop a limited set of core questions to be included in a more balanced set of surveys covering a range of settings, services, pathways and patient groups.

“Listening to patients – asking, reporting, and learning from patient experience – will be of great importance in designing and improving services, including achieving greater efficiency. But the NHS too often asks insufficiently penetrating questions, insufficiently often, of too few patients.”

Andrew Lansley MP,  
Secretary of State for Health<sup>6</sup>

**Patient experience:** feedback from patients on ‘what actually happened’ in the course of receiving care or treatment, both the objective facts and their subjective views of it. The factual element is useful in comparing what people say they experienced against what an agreed care pathway or quality standard says should happen. The opinion element tells you how patients felt about their experience and helps to corroborate (or otherwise) other quality measures. Some measures, such as waiting, can be derived from routine data rather than patient feedback.

**Patient feedback:** the generic term for any information gathered directly from people in relation to their care or treatment.

**Patient satisfaction:** ‘how people felt’ about their care or treatment – a subset of wider patient experience measures. People evaluate the quality of their care against an explicit or implicit set of standards or criteria, which can be useful in helping to rate the importance of different elements of care and in providing a simple overall rating. Satisfaction measures alone can be difficult to interpret given variations in people’s expectations of care.

**PROMs:** patient-reported outcome measures, concerned with ‘whether the treatment worked’ from the patient’s perspective in improving their health status and quality of life. PROMs are outside the scope of this project.

**Real-time measurement:** techniques for seeking people’s feedback soon or immediately after experiencing care, often using electronic devices or online channels. They can deliver high volumes of rapid feedback, and are also flexible enough to enable service-level comparisons and to focus on different issues at different times. They will not necessarily deliver a statistically representative sample of views.

**Routine data:** patient administrative data collected as a matter of routine to record hospital activity. Routine data may provide the source for some measures of patient experience not derived from direct patient feedback.

## Other relevant topics

**Net promoter score (NPS):** this is a score based on a single question, “On a scale of 1-10, how likely is it that you would recommend this provider to a friend, relative or colleague?” followed by an open why/why not question. We include it here as it is becoming increasingly popular in the NHS, having been widely adopted in other service industries. However, many are also sceptical of its value and prefer composite scores (as proposed in the Outcomes Framework currently out for consultation), which do give an overall score but also allow drilling down to better understand the factors affecting the overall score.

**Patient and public engagement:** wider processes designed to build ongoing relationships and dialogue with patients and local communities, “an approach to involving and empowering the people using services, and taking their experiences into account” (DH).<sup>7</sup> Patient feedback is just one key element in a patient and public engagement strategy.

## Signpost

[References and acknowledgements](#) p22-23

# The current state of play

In 2010, patient experience is still an area characterised more by positive rhetoric and good intentions than by consistent and widespread good practice. Judging by comments made in response to our *Intelligent Board* surveys, many trusts consider themselves to be in the early stages of a significant journey and have a strong sense that they could do a lot better. This sentiment was confirmed by our review of a large number of board papers and minutes. Several survey respondents also told us that the past year and the findings of the Mid Staffordshire inquiry have brought a greater sense of urgency to the task.

On the other hand, a number of non-executive directors appear to feel surprisingly sanguine about the quality of board-level information in this area. In our survey of non-executives, 72 per cent told us they feel informed or well-informed about patient experience. More than half estimated they spend less than 10 per cent of board time and attention on patient experience matters.

**“Getting patient experience measurement sorted out is no small task, but the real challenge is making the shift from reporting data to learning the lessons and taking action.”**

**Anne Marie Lavery**, Director of Patient Experience, Northumbria Healthcare NHS Foundation Trust

### Comments from our research

“The patient experience has been given a much higher profile over the past 12 months. All activity is new but moving in the right direction.”

*Non-Executive Director, Acute Trust, Intelligent Board Survey*

“We have a patient experience report at each board meeting but this hasn't provided adequate information on actual experience.”

*Non-Executive Director, Foundation Trust, Intelligent Board Survey*

“What do I find most useful? Individual stories with which to compare the aggregate data.”

*Chair, Primary Care Trust, Intelligent Board Survey*

“Is the balance right between full board discussion and delegated activity? I have the sense that more should be brought to the board.”

*Non-Executive Director, Acute Trust, Intelligent Board Survey*

“Try asking what your patient experience director has spent most of their time on this month.”

*Non-Executive Director, Acute Trust, Intelligent Board Interview*

## More key findings from our surveys and board review

- We found few examples of local patient experience priorities or targets being set as part of annual plans and tracked accordingly, with the exception of nationally mandated indicators.
- 60 per cent of acute trusts and all mental health trusts said they report patient experience data monthly (or at every meeting, where they are held less often). All of these are able to report some patient experience data (or satisfaction data) with a time lag of less than a month. The remaining trusts report patient experience data on an exceptions basis.
- Board reports on patient experience vary from one overall traffic light to 100 pages of closely packed detail.
- Local patient surveys: 66 per cent of provider trusts survey all wards and 60 per cent survey all specialties; 93 per cent cover at least half of all wards and 92 per cent cover at least half of all specialties.
- No examples were found of trusts benchmarking their patient experience performance against peers; there was one example of benchmarking against the national average.
- No examples were found of reports which actively linked qualitative and quantitative patient experience data – or patient experience data with clinical safety or effectiveness measures.
- 85 per cent of provider boards use reports from walkrounds as part of their patient experience reporting.
- 43 per cent of non-executives told us that patient experience is always an integral part of quality discussions at their board meetings.
- 81 per cent of non-executives said that there is a substantive discussion of patient experience either quarterly or at every meeting.
- 100 per cent of providers report the results of complaints and national surveys at board level; 38 per cent report complaints monthly.
- Of the trusts who regularly report on complaints with any level of detail, 40 per cent report only numbers and process measures while 60 per cent give further analysis of themes and resulting actions.
- Our analysis of board papers showed that, for more than 95 per cent of agenda items on patient experience, the minuted action point was to note the report.
- Patient experience rarely featured in the chair and chief executive reports that we reviewed.

**“Over-estimating what they were measuring, the quality of the information received at board level and what they were doing with it were also common themes of our baseline survey on patient experience in 2008.”**

**Mandy Wearne**, Director of Service Experience, NHS North West

# References

- 1 Speech at the publication of the final report, 2nd March 2010. Available at: [www.midstaffsinquiry.com/news.php?id=30](http://www.midstaffsinquiry.com/news.php?id=30) (accessed 12.08.10).
- 2 Fremont AM, Cleary PD, Hargraves JL, Rowe RM, Jacobson NB, Ayanian JZ, Patient-centered processes of care and long-term outcomes of myocardial infarction, *J Gen Intern Med* 2001, 16:800-8.  
  
Kaplan SH, Greenfield S, Ware JE, Assessing the effects of physician-patient interactions on the outcomes of chronic disease, *Med Care* 1989, 110-127.  
  
Stevenson FA, Cox K, Britten N, Dundar Y, A systematic review of the research on communication between patients and health care professionals about medicines: the consequences for concordance, *Health Expectations* 2004, 7(3):235-245.
- 3 Berwick D, Connecting finance and quality, *Healthcare Financial Management* 2008, Oct:53-55.  
  
DiGioia A, Greenhouse P, Levison T, Patient and family-centered collaborative care: an orthopaedic model, *Clinical Orthopaedics and Related Research* 2007, 463:13-19.  
  
*Does Improving Quality Save Money?*, Ovretveit J, The Health Foundation, 2009.  
  
*Patient-Centered Care: What Does It Take?*, Shaller D, Commonwealth Fund, 2007.  
  
'Performance pays', Premier Inc. Available at: [www.premierinc.com/quality-safety/tools-services/p4p/p4p.jsp](http://www.premierinc.com/quality-safety/tools-services/p4p/p4p.jsp) (accessed 12.08.10).  
  
*Putting Patients First: Best Practices in Patient-Centered Care*, Frampton SB, Charmel P, 2008.  
  
Yasaitis L, Fisher ES, Skinner JS, Chandra A, Hospital quality and intensity of spending: is there an association?, *Health Affairs* 2009, 28:566-572.
- 4 *Building on the Best: Choice, Responsiveness and Equity in the NHS*, DH, 2003.  
  
*Core Domains for Measuring Inpatients' Experience of Care*, Picker Institute Europe, 2009.  
  
*Crossing the Quality Chasm: A New Health System for the 21st Century*, Institute of Medicine, 2001.  
  
*Frontiers of Performance in the NHS II*, Ipsos Mori, 2008.  
  
*Key Domains of the Experience of Hospital Outpatients*, Picker Institute Europe, 2010.  
  
'New reporting requirements put quality at top of board agenda', *Monitor*, 23rd April 2009. Available at: [www.monitor-nhsft.gov.uk](http://www.monitor-nhsft.gov.uk) (accessed 12.08.10).  
  
*Putting People at the Heart of Care: The Vision for Public and Patient Experience and Engagement*, DH, 2009.
- 5 Tables adapted from *The Point of Care: Measures of Patients' Experience in Hospital: Purpose, Methods and Uses*, Coulter A, Fitzpatrick R, Cornwell J, The King's Fund, 2009.
- 6 'My ambition for patient-centred care', 8th June 2010. Available at: [www.dh.gov.uk/en/mediacentre/speeches/dh\\_116643](http://www.dh.gov.uk/en/mediacentre/speeches/dh_116643) (accessed 12.08.10).
- 7 *Putting People at the Heart of Care: The Vision for Public and Patient Experience and Engagement*, DH, 2009.

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## Intelligent Board surveys

In preparing this report, we surveyed NHS organisations via their chairs and chief executives, with the aim of taking a snapshot of how patient experience is currently being reported to NHS boards. We also surveyed non-executive directors to gauge their perceptions of the patient experience information they receive.

## Board review

For a total of 33 NHS organisations, we studied a full annual cycle of board papers and minutes to understand the coverage of matters relating to patient experience. These organisations, which included 15 acute trusts, 12 primary care trusts, five mental health trusts and one learning disability trust, were selected to provide a spread in terms of factors such as size, region and demographics. We included three trusts specifically in light of serious failings identified by the CQC.

Further details of the surveys and board-paper review can be found online at [www.drfooster.co.uk/patientexperience](http://www.drfooster.co.uk/patientexperience)

## The Point of Care programme

The Point of Care programme at The King's Fund aims to help healthcare staff in hospitals to deliver the quality of care they would want for themselves and their own families. The programme works with patients and their families, staff and hospital boards to research, test and share new approaches to improving patients' experiences. Visit [www.kingsfund.org.uk/pointofcare](http://www.kingsfund.org.uk/pointofcare) for more information.

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