

Rethinking policy approaches to measuring and improving patient experience

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Rethinking policy approaches to measuring and improving patient experience

Patients' experiences are increasingly central to assessing the performance of health care worldwide. Alongside measures of clinical effectiveness and patient safety, the patients' views of their experience are now commonly used to judge the quality of care.^{1–3} However, in the context of a range of policy concerns including ensuring value for money, ambitions to make services patient-centred, preventing organizational failures and increasing accountability to local communities, it is timely to take stock of current approaches to measuring patient experience and ask whether they are fit for such a wide variety of purposes.

Where are we now?

Internationally, the National Health Services (NHS) in England led the way in mandating a national patient survey in 2001. The first similar public reporting was in 2008 in the USA with the Hospital Consumer Assessment of Healthcare Provider and Systems (HCAHPS) survey. Australia, Canada, New Zealand and most European countries (with the exception of the Netherlands and Norway) do not have systematic arrangements for measuring and monitoring patients' experience at national level although they do exist at regional and state levels in some countries. In contrast, England has several years data on patients' experience in acute, mental health and primary care organizations, as well as in specific services (for example, maternity services and emergency departments). The surveys are extensive with the most recent inpatient survey including 70 items.

Such national survey data are valuable for monitoring because they are based on randomly selected representative populations, the questions are standardized and it is possible to compare organizations and track trends over time. With these important features, the national patient survey in England has served the need of policy makers, in a publicly funded health care system, to hold health care organizations to account for the experience they provide to their patients. And when combined with clear, centrally driven and funded priorities (such as hand washing and other initiatives to reduce health care acquired

infections or the provision of single sex accommodation) then the survey programme has played an important part in helping to bring about improvements in the safety and humanity of health care quality.

However, paradoxically, leaders of local health care organizations have largely not used the results to formulate their own strategic goals to improve patients' experiences. Indeed, the survey programme may have contributed to the failure of hospital management boards to reflect sufficiently on their own responsibilities for collecting and using patient experience data to improve the quality of local services. It appears that the very existence of national surveys has contributed to a tick box or compliance mentality on the part of management boards. The survey programme may have lulled them into thinking that they were paying attention to their patients' experiences. For instance, and despite examples of good practice, a review of management board agendas and minutes from a sample of hospitals found that patient experience data were rarely used to spark debate and action.⁴

Anecdotal evidence suggests many clinicians do not believe that generic outpatient or inpatient surveys reflect the experiences of their patients and complain that the data are frequently out of date. Certainly, at ward and service level, there is little evidence that most clinical teams and middle-level managers make use of national patient survey data to monitor service quality and drive local quality improvement.⁵ A review of 41 research papers explored how the 600,000 patient responses to the national inpatient survey from 2002 to 2009 had been used. It concluded that 'the inpatient survey is not in itself a quality improvement tool' and that 'simply providing hospitals with patient feedback does not automatically have a positive effect on quality standards'.⁶

In a recent survey of hospital clinicians in Denmark, Israel, England and the USA, the current situation has been portrayed as a 'chasm' between senior leaders and frontline clinicians.⁷ Only 9.2% of over 1000 respondents thought their department had a structured plan for improving patient satisfaction and that 85.5% of clinicians thought that hospital managers should take a more active role in conducting patient satisfaction

improvement programmes. Related to this, 41% of almost 150,000 staff in the English NHS in 2011 said they had not received training in improving patients' experiences and 22% said it was not applicable to them.⁸

Whilst hospitals have traditionally relied, perhaps over-relied, on national patient surveys to provide insights into specific aspects of patients' experiences of care, they are increasingly deploying a wide range of other methods and approaches locally.^{9,10} There has been a recent proliferation in methods and approaches, often qualitative, for capturing and helping improve patient experience. The value of these innovations and initiatives lies in a greater sense of local ownership and service relevance. However, local questionnaires often lack standard questions; we found 18 versions of a question about dignity and respect.¹¹ This creates difficulties in making sense of a plethora of data that cannot be used to compare with others or even within the service over time.

Measures and systems for the future

In England, there has been a lack of serious and sustained local attention to improving patient experiences in all but few health care organizations. The picture is one of compliance with monitoring requirements rather than ownership and motivation to improve this key component of quality. Under certain conditions, national surveys are useful. In tandem with national or local incentives, the results can spark a drive to improve aspects of patient experience and can play an important role in monitoring progress over time and benchmarking. Often, however, it appears that results of patient experience surveys do not intrinsically appeal to clinicians and nor are they meaningful to patients.

What lessons might help policy makers who want to improve patient experience of health care, strengthen the patient voice and make services more accountable to local communities and patients? A recent report to the Department of Health in England proposed several design rules for developing the next phase of national policies in this area:¹²

- apply common criteria for assessing indicators of clinical quality and patient safety (timeliness, relevance and validity) to patient experience and design measures and measurement systems accordingly
- closely align what is measured with what matters most to patients
- evaluate patients' experiences of whole pathways of care, with a focus on continuity and the co-ordination of care
- move away from 'discovery' and towards 'auditing' whether experiences are meeting set standards
- make much better use of existing information sources, including complaints data
- support as close to 'real-time' data collection as possible.

Regarding this last point, we recognize the limitations of existing real-time approaches but believe that timeliness of insights into patient experiences is critically important if this core dimension of quality is to secure and retain credibility with staff working at the frontline.⁵

To meet these parameters, we propose a single (not composite) overarching indicator to be collected as near to real time as possible at the service level. (currently in England the 'Friends and Family' test is being piloted in this regard),¹³ alongside a very limited number of questions on 'what matters' to patients that focus on relational aspects of their care (as guided by the Institute of Medicine dimensions of patient-centred care). Such an approach could better meet the needs of both health care policy makers and practitioners in three ways: by aggregating the overarching indicator and other items to organizational level to inform performance monitoring; by the use of a simple and straightforward overarching indicator to provide transparency; and by measuring what matters most to patients at the service level in a timely and regular fashion to guide local quality improvement. In combination with local qualitative approaches (such as patient stories) that capture the rich details of patient experiences and a planned change process for improving services on the basis of patient feedback, we believe a national patient feedback programme revised on these lines would better serve the health system and patients.

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