



New Zealand Health Quality & Safety Commission

Development of patient experience
indicators for New Zealand

Final report

June 30, 2013

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Definitions

The term *consumer experience* and *customer experience* are referred to in the document in sections 3 and 4. This is consistent with the terminology used by the New Zealand Health Quality and Safety Commission in outlining the objectives and scope of the project and in previous measurement activities undertaken in New Zealand. Elsewhere in the document the term *patient experience* is used for consistency with the international literature. The terms can be considered interchangeably.

1 Executive Summary

This project supports delivering better quality health care for all New Zealanders. It aims to achieve this by initiating the work required to measure and report how consumers or patients actually experience the health system. What happened to them and how did it make them feel? By capturing this consistently and coherently across New Zealand's health system, this information can be used to make substantial improvements to both the experience and the actual quality of care received. This is a critical investment for New Zealand's health system and an investment for all the people of New Zealand.

Currently, New Zealand has no consistent approach to measuring, reporting and managing patient experience performance, at the national and local level. This presents an opportunity to develop a comprehensive national framework, with national priorities and mechanisms to drive focused improvement initiatives.

One of the key objectives of the New Zealand Health Quality and Safety Commission (the Commission) is to lead and coordinate work across the health and disability sector. The Commission's overall programme of work is underpinned by the New Zealand Triple Aim framework for quality and safety outcomes. This includes a specific aim of 'improved quality, safety and experience of care'. The patient experience indicators, proposed as a result of this project, will form part of the Commission's broader Health Quality & Safety Indicator set.

Project objective

The objective of this project was to identify consumer experience indicators at three levels:

- National: Commission indicator framework
- District Health Board (DHB) level: Accountability
- Service-level: Improve services.

These indicators can then be used to improve the quality and effectiveness of consumer/patient care and experience on a national and local level. They can also be used by the Ministry of Health (the Ministry) to strengthen accountability.

Guiding principles of project: Consistency with international best practices and local initiatives

Recommended measures are aligned with international best practice and global trends in measuring patient experience. The project is also aligned with and supports the series of related initiatives underway in the New Zealand health sector.

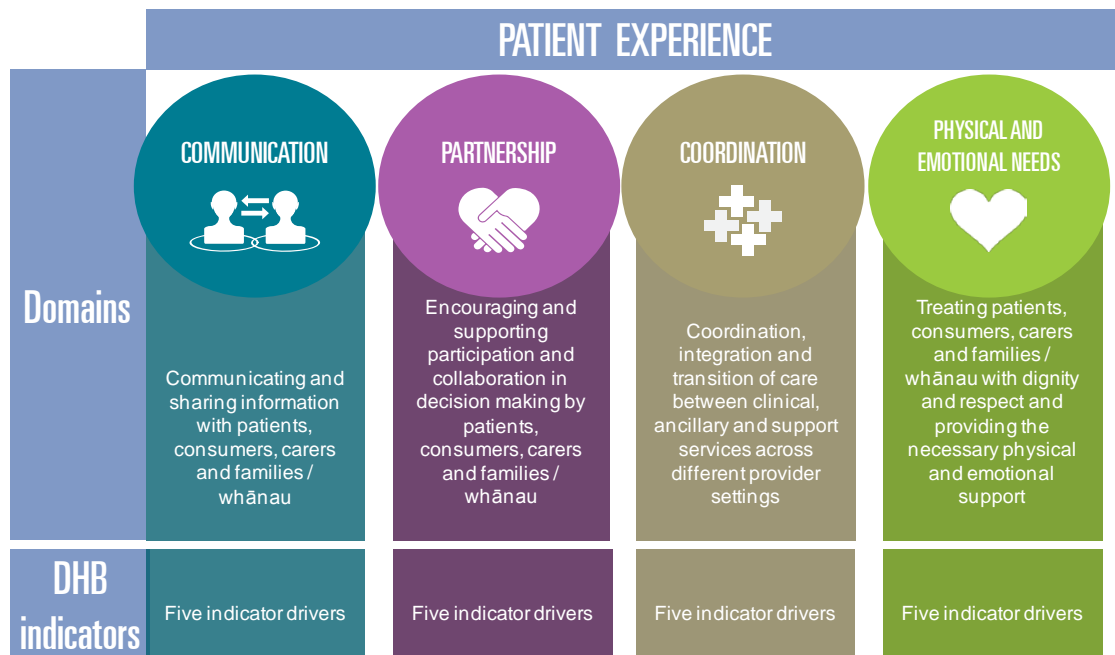
In developing the framework for New Zealand, the approach of the three recognised, international leaders of patient-centred methods of measuring the patient experience has been used as the foundation. These include the Picker Institute, the American Consumer Assessment of Healthcare Providers and Systems (CAHPS) and the Dutch

Consumer Quality Index (CQ-index). The broad adoption of the Picker Principles highlights the international applicability of the domains of patient experience. The domains have remained relatively unchanged and unchallenged since their development despite significant analysis and review. For this reason, these principles were used as a foundation for the Commission to consider New Zealand’s approach to prioritising the measurement of patient experience.

The project includes the following recommendations and findings

Recommendation 1: Measuring patient experience should be based on four domains, each with five indicator drivers reflecting what is important to patient experience across primary and secondary care environments

Four domains have been selected that are closely aligned with current international best practice. For each domain five indicator drivers have been identified that could be measured at the national and local DHB level across primary (and broader community care) and secondary (and broader hospital based care) settings. These domains received broadly positive feedback during consultation exercises. Feedback was received from over 60 people representing DHBs, consumer groups, the Ministry and primary care in two workshops plus meetings with the Ministry of Health and an e-questionnaire. The four recommended domains are as follows:



- Domains denote the patient experience priorities for New Zealand
- Domains frame the indicators at the national and DHB level

In essence, selecting these four domains is saying that a high quality experience for patients and consumers depends upon high quality and effective communication, a

real partnership, excellent and seamless coordination of care and meeting both the physical and emotional needs of the patient.

Recommendation 2: A patient experience survey should be developed based on individual survey questions asked directly of patients. Qualitative measures including patient stories, focus groups and interviews can also be used to complement the surveys and provide additional detail at a local level

Indicators should be constructed using individual survey questions asked directly of patients, or indirectly through a carer, relative/whānau or nominated friend. Surveys should be available to patients online, in paper form and in other media, including translated versions for non-english speaking respondents. Surveys should also be accessible to people with physical or intellectual disabilities. Survey questions should be weighted to allow patients to reflect indicator drivers and domains most important to their patient experience.

Recommendation 3: The results of survey questions should be aggregated to measure the five indicator drivers within each domain. The indicator drivers should then be aggregated to develop a single indicator for each domain

Indicators should be aggregated to populate DHB and national indicators, which in turn should be aggregated to provide a single indicator for each of the four domains. Aggregation should include patient weightings from the survey so that indicators reflect what is most important to patients' experiences.

Recommendation 4: The aggregation of national indicators at a domain level should be used to drive accountability

Measuring patient experience indicators is a necessary first step, but on its own is not sufficient to achieve the Commission's goal of a better experience for all patients.

An effective performance management framework is critical to ensure formal and regular monitoring and reporting occurs within all health organisations. This should include clear responsibilities and accountabilities for using the information. It should also include triggers to act on exceptions, and effective governance arrangements to close the loop from an assurance point of view by senior leaders and board members.

Assessment at a domain level should form the basis for accountability; however, detailed questions used to populate DHB indicators would be used to drive performance improvement. These lower level indicators could act as the diagnostic to understand the cause and identify corrective actions.

Recommendation 5: DHB indicators and responses to survey questions should be reported and monitored by DHBs/providers

DHB indicators and responses to survey questions should be reported and monitored so that subtle changes in indicator performance at the aggregated level do not mask significant changes in individual indicators or responses to survey questions.

Finding: One single overarching indicator is methodologically feasible

One overarching indicator based on the aggregate of the four domains is methodologically feasible. A single measure or indicator of patient experience indicator is also possible, however this would not enable the ability to 'drill down' to lower indicator levels, as would be possible using an aggregated, overarching indicator (i.e. drill down is possible from the overarching indicator to domain indicators, then to indicator drivers, and ultimately to survey questions).

Recommendation 6: The roll out of a survey should be in full across all areas of health and all domains rather than by a piecemeal or phased approach

The roll out of the survey should be undertaken in full, across all areas of health and across all domains rather than in a phased or piecemeal approach. This will be necessary to establish a robust measure of patient experience across all areas of health and should be built on by undertaking regular measurement. This approach will also realise the full benefits of the accountability framework. Work to develop the survey should start immediately with the aim of collecting data from December 2013.

Finding: There is a compliance burden and cost associated with a survey that is dependent on the survey methodology selected

Consideration should be given to the resourcing requirements to deliver the necessary measurement activities and to support the functioning of a robust accountability framework. This will be dependent on the final measurement approach selected by the Commission and the roles and responsibilities associated with implementation.

Appropriate methodological support will be necessary to ensure that the questions underpinning the survey are robust and cognitive tested.

Recommendation 7: Further consultation

The evidence base and support from the consultation process is robust, however there was strong interest for additional stakeholder consultation to test further the appropriateness of DHB indicators. Consultation will also be important in developing an effective and supporting accountability framework, once DHB indicators are finalised.

Concluding remarks

This report represents the start of the journey. It is the first critical milestone on a journey towards a consistent and coherent patient experience measurement framework that drives better quality care. By building on experience globally, it also represents an opportunity for New Zealand to create a leading approach that best helps patients while creating minimum burden for those that apply it.

By determining what to measure at the national and DHB level, this project represents the first critical step in a journey. This is the journey to establish, embed and apply a coherent set of national patient indicators across New Zealand's health system that is



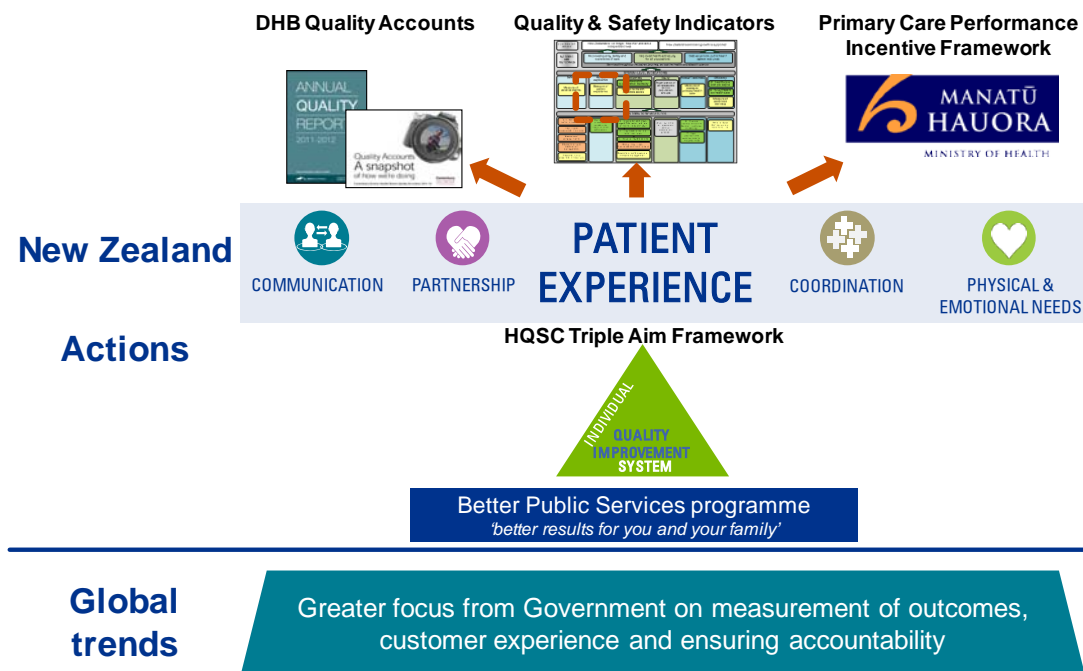
used to drive improved quality care. Following on from this project, significant work remains to determine how best to measure the domains and indicators identified and how to implement this framework.

2 Background

2.1 Background and context to this project

This project to develop measures of patient experience aligns with international best practice, global trends in measuring outcomes, and customer experience and a series of initiatives underway in the New Zealand health sector. The figure below illustrates the global context and indicates the linkage of this project with other initiatives being undertaken across the health sector. These main initiatives and how they support one another are illustrated in the figure below and then described briefly.

Figure 1 Background and context to measuring patient experience



Global trends and Better Public Services

There is growing interest by governments, both within New Zealand and internationally, to focus on measuring the customer’s experience with services. The New Zealand Government’s Better Public Services Programme seeks to ensure public services are more innovative, enterprising, driven, and focused on better results ‘for

you and your family’¹. New Zealander’s satisfaction with public services is cited as a key measure of the programme.

The Commission’s triple aim framework

Within the Health sector, the Commission’s overall programme of work is underpinned by the New Zealand Triple Aim framework for quality and safety outcomes which includes a specific aim of ‘improved quality, safety and **experience** of care’².

Health quality & safety indicators

The patient experience indicators, proposed as a result of this project, will form part of the Commission’s broader Health Quality & Safety Indicator set³. The indicators cover a range of aspects of quality and safety including:

▪ Safety	▪ Equity
▪ Patient experience	▪ Access / timeliness
▪ Effectiveness	▪ Efficiency

DHB Quality Accounts

The Commission is supporting DHBs to produce Quality Accounts. Quality Accounts require health care providers to give an account of the quality of their services in a similar way to financial accounts which indicate how an organisation has used its financial resources⁴. A key focus area within the Quality Accounts is how to improve consumer experience with services.

Both the Quality Accounts and Health Quality and Safety indicators lack a consistent national approach to measuring patient experience. The domains and indicators proposed by this project aim to help to provide the consistency required.

¹ National Party of New Zealand (2012) ‘Better Public Services. Available’ at <http://www.national.org.nz/public-services.aspx>

²Health Quality & Safety Commission (2013) ‘About the Commission’ Available at <http://www.hqsc.govt.nz/about-the-commission/>

³ Health Quality & Safety Commission (2013) ‘Health Quality & Safety Indicators’ Available at <http://www.hqsc.govt.nz/our-programmes/health-quality-evaluation/projects/health-quality-and-safety-indicators/>

⁴ Health Quality & Safety Commission (2013) ‘Quality Accounts’ Available at <http://www.hqsc.govt.nz/our-programmes/health-quality-evaluation/projects/quality-accounts/>



Primary Care Performance Incentive Framework

The Primary Care Team, within the Ministry of Health, are currently developing a performance framework for primary care within a whole of system context. This project replaces the current Primary Health Organisation (PHO) Performance Programme which seeks to improve the health of enrolled populations and reduce inequalities in health outcomes through supporting clinical governance and rewarding quality improvement within PHOs⁵. Again, the domains and indicators proposed by this project aim to help to provide consistency.

Alignment to other Ministry initiatives

The Ministry of Health has several initiatives underway that also consider patient experience. In order to avoid duplication and ensure alignment with these other initiatives, KPMG and the Commission have met with representatives from the Ministry's Health of Older People, Primary Care, DHB Accountability and Policy teams on three occasions to update them on this project's progress and to seek feedback. In general, feedback has been very positive with a view that this work will help to support these initiatives.

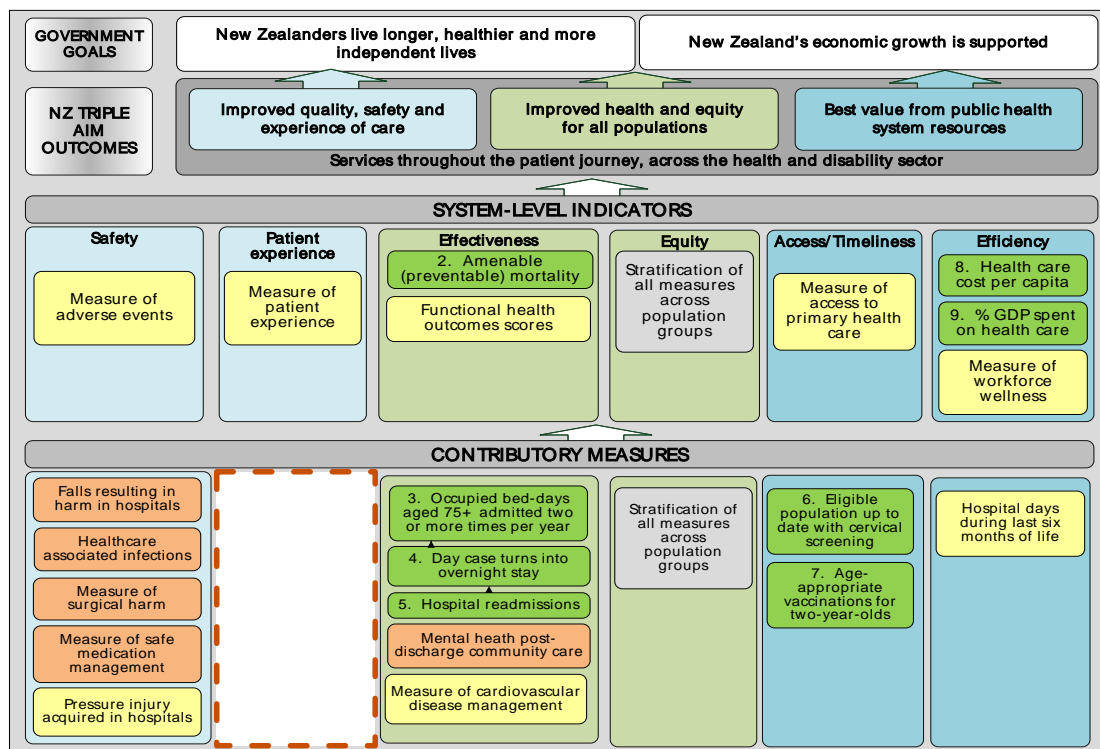
⁵ DHB Shared Services (2013) 'PHO Performance Programme'
<http://www.dhbsharingservices.health.nz/site/sig/pho/>

3 Introduction

3.1 Context, objectives and scope

Within the Commission’s Outcomes Framework, patient experience is a core system level indicator (see figure below). The addition of indicators (to be referenced as “contributory measures” to this framework) is necessary to develop a comprehensive outcomes framework.

Figure 2: Health Quality and Safety Commission Outcomes Framework



Within this context, the objective of this project is to identify consumer experience indicators at three levels:

- National: Commission indicator framework
- DHB-level: Accountability
- Service-level: Improve services.

This objective aims to facilitate the improvement of consumer/patient care experience at a national and local level, and be used by the Ministry of Health to strengthen accountability.

The development of consumer/patient care experience indicators was guided by the following principles. Indicators should:

- Contribute to measuring the Commission’s “Triple Aim” from the outcome framework, specifically how consumer experience supports “Improved quality, safety and experience of care”⁶
- Measure performance across the health system by enabling indicators to be compared nationally, between DHBs, and at a local service level
- Enable benchmarking, both nationally and internationally, as an important technique to drive accountability and performance improvement
- Are transparent and based on evidence from the literature regarding what has been successful in other jurisdictions (i.e. build on existing work)
- Are relatively simple to create and populate from readily available information from all DHBs and services
- Involve key stakeholders in development so that they are owned and accepted
- Provide a clear line of sight for accountability arrangements to drive performance improvement
- Are broadly inside the sphere of influence of the DHBs where they are to be held accountable for performance.

Finally, the overarching principle or measure of success is that the indicators and measurement framework acts as a driver of performance improvement.

The scope of this project covers identifying, developing and project managing the process to draft, consult on and finalise measures of patient experience for DHB funded services. The scope includes a definition of the requisite data collection source, but not the methodology or resourcing activities associated with implementation. Some of these considerations have been detailed in section 9 - Suggested next steps.

The scope included due consideration of how indicators could be used to support DHB accountability arrangements and DHBs’ efforts to respond to patients’ experience of individual services. This did not include recommending how of an accountability framework should be applied or how the Ministry should uphold accountability. The overarching performance management/accountability framework and associated functions needs to be developed separate to this project and once measurement indicators are finalised. We have detailed some of the key factors for the Commission to consider in relation to accountability issues in section 9.

⁶ Health Quality & Safety Commission New Zealand (2013). Statement of Intent 2012 to 2015. Available at http://www.hqsc.govt.nz/assets/General-PR-files-images/HQSC_SOI-2012-Final.pdf. Accessed on 27 May 2013.

4 Patient experience indicators in New Zealand

4.1 Previous measurement: discontinued survey

The Ministry of Health and Crown Company Monitoring Advisory Unit (CCMAU) developed a National Patient Satisfaction Survey and supporting guidelines in 2000. All DHBs in New Zealand were required to survey their patients according to these guidelines.

The National Patient Satisfaction Survey was paper-based, and separate surveys were developed for inpatients and outpatients, each with standard questions for all DHBs. The inpatient questionnaire asked about a series of areas, including:

- patient perceptions of the Emergency Department
- the availability of staff
- the manner in which patients were treated by staff
- their opinion of the hospital's facilities (safety and security, cleanliness, food)
- discharge procedures
- the adequacy of communication between different departments involved in their care.

The outpatient questionnaire asked about:

- patient perceptions of the appointment system
- the manner in which patients were treated by staff
- patient opinion of the clinic's facilities
- the adequacy of communication between different departments involved in their care
- their satisfaction with the organisation of their care with other service providers⁷.

In May 2011, a project was initiated by the National Quality & Risk Managers Group, (comprising the Quality & Risk Managers and supporting advisors from the 20 DHBs), to review the current approach to collecting information on consumer experience. This project was driven by concerns raised by DHBs about the current way this information is captured and whether the National Patient Satisfaction Survey is 'fit for purpose'.⁸

⁷ Health Services Consumer Research Limited. (2009). Patient satisfaction in New Zealand. *Journal of the New Zealand Medical Association*, 122 (1300), 38-49.

⁸ National Quality and Risk Managers Group. (2011). *Capturing the Consumer Experience - Project Report and Recommendations*.

Subsequent to this project, the Ministry withdrew the mandate for DHBs to issue the National Patient Satisfaction Survey and required that DHBs establish a system for capturing consumer experience information by September 2013.

4.2 Current state of patient experience indicators

The majority of DHBs do not have a framework for measuring DHB-wide consumer experience.

- **Some DHBs** indicated they have consumer involvement strategies, policies for feedback and complaints management
- **Most DHBs** indicated that individual wards, departments or services have consumer experience initiatives but that these are not embedded into a DHB wide framework
- **Several DHBs** are exploring ways to improve their consumer experience programmes

Current DHB processes

Information on current DHB processes was collected as part of this project in order to:

- understand where DHBs have developed particularly innovative processes to collect consumer experience information
- identify instances when DHBs have existing indicators and historical data to measure these indicators
- assess the readiness of DHBs to implement national consumer experience indicators
- assess the feasibility and additional burden of implementing national consumer indicators.

The information collected from DHBs was used to inform the development of consumer experience indicators and, where possible, existing practices and datasets were leveraged. To understand processes used by DHBs, a short questionnaire was issued to all 20 DHBs. This questionnaire asked DHBs to describe:

- current consumer experience indicators
- methods used to collect data on consumer experience
- how consumer experience information is used to improve processes
- reporting within their DHB on consumer experience.

DHBs were also asked to describe what is working well, what is not working well with their current processes, and to rate their DHB’s current consumer experience indicators.

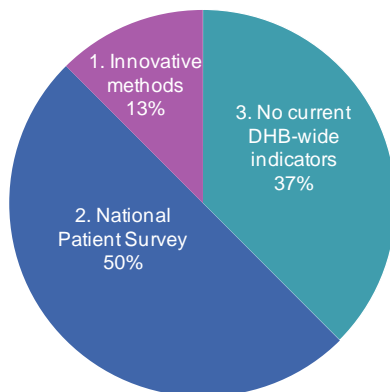
Almost all DHBs (90% or 18 of 20) responded to the questionnaire, representing a mix of metropolitan and rural DHBs. Responses from DHBs were analysed for themes and particular areas relevant to this project.

Current consumer experience processes

The questionnaire required DHBs to respond to a series of questions to indicate, at a broad level, the context of each DHB’s consumer experience processes. The survey identified that:

- the majority of DHBs do not have a framework or overarching policy for measuring consumer-wide experience
- some DHBs indicated that they have strategies for involving consumers and policies for seeking feedback and managing complaints
- several DHBs reported that they were exploring opportunities to improve their consumer experience programs.

DHBs can be classified into one of three groups based on their current consumer experience indicators:



1. DHBs that have implemented individualised and innovative consumer experience processes to collect information at a DHB-wide level. Examples of innovative practice include using consumer stories, focus groups, social media and online discussion forums to obtain feedback. Several DHBs have provided kiosks in outpatient and discharge lounges and portable tools (for example tablets) to collect feedback.

2. DHBs that are using the National Patient Satisfaction Survey as their primary tool for analysing DHB-wide consumer experience. These DHBs have continued to administer and analyse the results of the Ministry of Health's National Patient Satisfaction Survey.

3. DHBs that have ceased to use the National Patient Satisfaction Survey and are currently not collecting DHB-wide information on consumer experiences.

All DHBs in groups 1-3 above are capturing consumer experience information for certain individual services. Certain services, in particular maternity and mental health, are required to administer specific consumer satisfaction surveys by the Ministry of Health.

Indicators currently used by DHBs

DHBs collecting DHB-wide information on consumer experience reported that they had implemented a range of consumer experience indicators. Examples of indicators currently used include:

- the overall rate of satisfaction with services received
- the percentage of positive responses (based on a Likert scale) to survey questions
- measure of the reach of the survey – the number of people who have responded to the survey compared with the number of people who have accessed the service
- the number of complaints or compliments per service
- Net Promoter Scores, a measure of the likelihood that a consumer would recommend a service to a friend or relative, specifically:
 - Would you recommend our hospital to your friends/family/whānau?
 - Would you recommend this service to your friends/family/whānau?

The burden of data collection

A key success factor identified by the Commission, Ministry of Health and KPMG at the initiation of this project was that the consumer experience indicators do not create an additional burden of time and effort on affected agencies. Our questionnaire asked 'based on your current methods to measure consumer experience, how feasible is it to continue to collect this information?'

Responses from DHBs varied substantially, with some DHBs indicating pressures with collecting consumer experience information in the current fiscal environment or challenges using volunteers. Other DHBs noted having sufficient capacity to collect this information as they had suspended the National Patient Survey. Several DHBs noted the importance of consumer experience information.

What is working well with current processes?

DHBs were also asked to describe elements of their current consumer experience processes that worked well. Only a few points were raised in response to this question. Comments raised were that:

- service-level surveys and measures were meaningful to the individual wards or departments as they were involved in the development and were tailored these to meet their needs
- DHBs continuing to use the National Patient Satisfaction Survey praised the consistency of the data provided and the ability to measure historical trends. Some of these same DHBs acknowledged the survey was less useful at an individual service, department or ward level
- one DHB reported that text message-based feedback systems worked well but did not receive the same volume of responses as traditional surveys
- processes to collect and analyse complaints were considered to be working well and an effective means of obtaining feedback from consumers.

What is not working well with current processes?

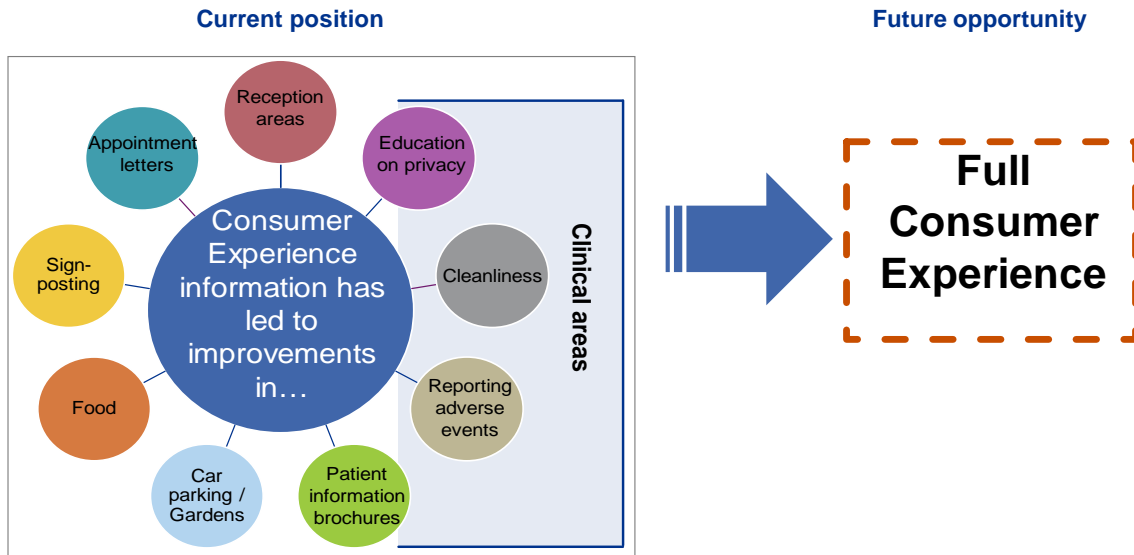
DHBs were also asked to describe elements of their current consumer experience processes that were **not** working well. More points were raised in response to what is not working well than what is working well. Common themes included that:

- information and consumer feedback could be better used to drive planning and action
- informal feedback 'on the spot' could be better captured
- the National Patient Satisfaction Survey is too labour intensive, with electronic solutions preferred
- the current approach to seeking feedback creates a risk that multiple surveys could be sent to the same patient
- service-specific surveys were inconsistent and not checked for user friendliness
- a lack of clarity over who was accountable for addressing feedback raised.

Using consumer experience information in order to drive improvement

Measures of consumer experience are a 'means to an end' and are ultimately used to **monitor** and **improve** the delivery of health services. DHBs were asked to identify any improvements to service delivery that their DHB had made as a result of consumer experience information collected. Figure 3 below presents common areas in which DHBs identified improvements that had been made in response to feedback.

Figure 3: Common areas where consumer experience information resulted in improvements and opportunity for improvement



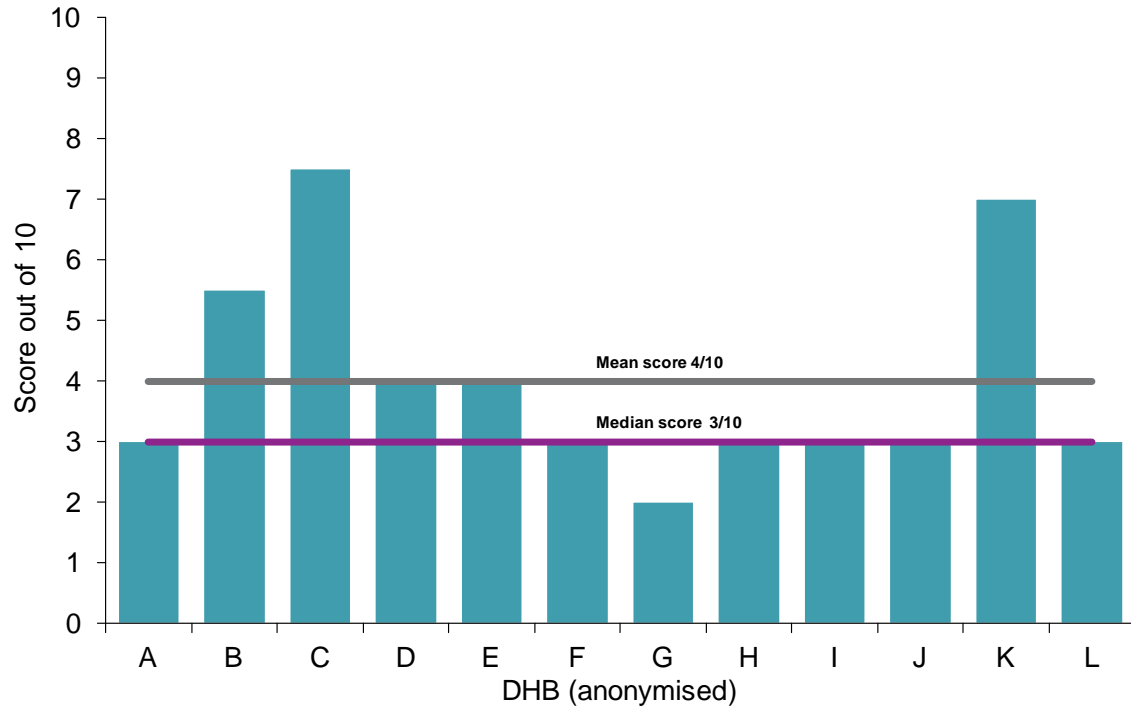
Self-assessment of current consumer experience indicators

Overall, the great majority of DHBs indicated that they believed there was substantial room for improvement compared to what was occurring currently.

DHBs were asked to provide an assessment of their current consumer experience indicators and the extent that these drive improvement. The assessment was measured on a scale of 1 to 10, where a score of 1 indicated a rating of “Poor” and a score of 10 indicated a rating of “Excellent” to the assessment. Responses were received from 60% of DHBs (12 of 20).

The mean score was 4 / 10 and the median score 3 / 10. This indicates a large opportunity to both improve consumer experience indicators and to use the data the measures collect to improve services. Figure 4 below analyses the results of this assessment.

Figure 4: How do you rate your DHB's current consumer experience indicators and the extent to which these drive improvement (n=12)



5 Understanding and improving the patient experience⁹: International perspective

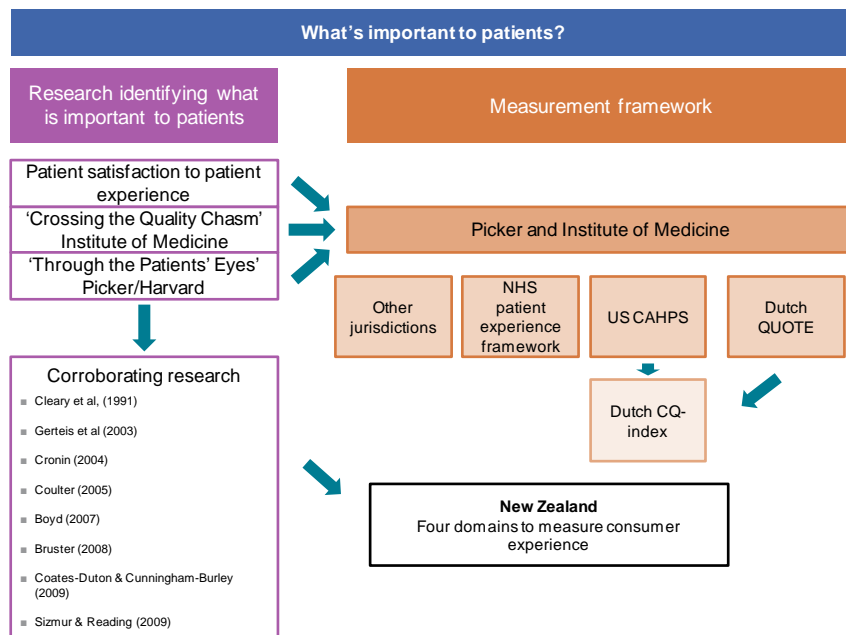
5.1 Evolution of patient experience measurement approaches

Patient experience indicators must be grounded in what is **important to patients**, rather than the priorities of clinicians, planners and administrators. The approach or framework must be patient centric in order to deliver measureable improvements that are of value to the patient and their families and whānau. In developing the framework for New Zealand, the approach of the three recognised, international leaders of patient-centred methods of measuring the patient experience should be considered. These are the:

1. Picker Institute
2. American Consumer Assessment of Healthcare Providers and Systems (CAHPS)
3. Dutch Consumer Quality Index (CQ-index).

Note that the latter two are influenced by the work of the Picker Institute.

Figure 5: International frameworks to identify domains



⁹ To reflect the approach in the literature, consumer experience is referred to as patient experience from this point forward in the report.

The Picker Institute has developed and refined the principles of patient centred care and the patient experience since the mid 1990s. The Picker Institute Principles of Patient-Centred Care (Picker Principles) are widely used for developing measures of the patient experience, with the CAHPS and CQ-index informed by the Picker Principles to some degree. The American CAHPS was developed by Harvard University based on the Picker Principles, the Dutch CQ-index is based on the CAHPS and the Quality of care through the patient's eyes (QUOTE) instruments. With some adaptation, the Picker Principles have been used successfully as the basis for measurement of patient experience in the UK, US, the Netherlands and Australia.

In the United Kingdom, the National Health Service (NHS) patient survey and patient experience framework are also based on modified versions of the Picker Principles. Modifications include the addition of elements regarding ensuring dignity, privacy and independence of service users, supporting decision making and supporting self-management. The coverage of Picker Principles in domains for patient experience also extends to Australia, where several state and territory based surveys reference the Picker Principles.

Alongside the Picker Principles, the Institute of Medicine's (IoM) six domains of patient centred care also represent a generic framework which measure 'what matters most' to patients. The two approaches are based on broadly the same primary research: 1) IoM 2001 'Crossing the Quality Chasm' report; and 2) Picker/Harvard 'Through the Patients Eyes' (Gerteis et al, 2003)¹⁰. However, the Picker Principles include the additional domains of "transition and continuity" and "access to care". A comparison of the two frameworks and their domains can be seen in Table 1.

¹⁰ The Kings Fund (2011) What matters to patients? Developing the evidence base for measuring and improving patient experience. Available at http://www.institute.nhs.uk/images/Patient_Experience/Final%20Project%20Report%20pdf%20doc%20january%202012.pdf. Accessed on 29 May 2013.

Table 1: Frameworks measuring what matters most to patients: Picker Principles and IOM domains of patient-centred care

Picker Principles of Patient centred care	The Institute of Medicine’s domains of patient-centred care:
1. Respect for patients’ values, preferences and expressed needs	1. Responsiveness to needs, values and expressed preferences
2. Coordination and integration of care	2. Coordination and integration
3. Information, communication and education	3. Information, communication and education
4. Physical comfort	4. Physical comfort
5. Emotional support and alleviation of fear and anxiety	5. Emotional support, relieving fear and anxiety
6. Involvement of family and friends	6. Involvement of family and friends
7. Transition and continuity	
8. Access to care	

The evidence base for the Picker Principles is founded on a multi-year research project, which was aimed at the development of scientifically validated patient-experience surveys. The research was conducted by the Picker/Commonwealth Program for Patient-Centred Care. The method included a national survey in the US of over 6,000 hospital patients and 2,000 care partners from 62 hospitals, and focus groups with patients and their family members.¹¹ The information garnered defined the patient’s perspective and led to the foundation of Picker surveys for the measurement of patient experience.¹² More recent studies confirm the robustness of the Picker Principles. Key articles by Boyd (2007), Bruster (2008), Cleary et al, (1991), Coates-Duton & Cunningham-Burley (2009), Coulter (2005), Cronin (2004), Gerteis et al (2003) and Sizmur & Reading (2009) are consistent with and further validate the seminal work that underpins the Picker Principles. The findings from these studies regarding what matters to patients across acute and primary care is summarised in Appendix B.

The broad adoption of the Picker Principles highlights the international applicability of the domains of patient experience. A comprehensive description of the Picker Principles is outlined in Appendix B. The domains have remained relatively unchallenged¹³ despite significant analysis, review, and some minor modification, as

¹¹ Gerteis et al (2003) ‘Through the Patient’s Eyes: Understanding and Promoting Patient-Centred Care’.

¹² The Kings Fund (2011) What matters to patients? Developing the evidence base for measuring and improving patient experience. Available at http://www.institute.nhs.uk/images/Patient_Experience/Final%20Project%20Report%20pdf%20doc%20january%202012.pdf. Accessed on 29 May 2013.

¹³ The Kings Fund (2011) What matters to patients? Developing the evidence base for measuring http://www.institute.nhs.uk/images/Patient_Experience/Final%20Project%20Report%20pdf%20doc%20january%202012.pdf. Accessed on 29 May 2013.



outlined above. For this reason, these principles were used as a foundation for the Commission to consider New Zealand's approach to prioritising the measurement of patient experience. The use of domains in describing, measuring and improving the patient experience has benefited health services and patients worldwide. As such, KPMG recommends that the Commission adopt a domain based framework in order to identify national priorities for the measurement of patient experience. This approach will enable clear alignment between the priorities, domains and subsequent indicators.

The domain based approach also enables clearer communication of the objectives, initiatives and measures, allowing measurement objectives to be embedded in the delivery system of care. This is a strong feature of the domain based framework in the UK, for example.

6 Establishing patient experience indicators in New Zealand

Domains of patient experience are used to align how health services are provided in order to meet the needs of patients. Currently, New Zealand has no consistent approach to measuring, reporting and managing performance, at the national and local level, related to patient experience. As such, New Zealand has an opportunity to develop a comprehensive national framework that not only measures patient experience but establishes national priorities and provides a mechanism to link these priorities with improvement initiatives.

The indicators should be seen in the context of a measurement approach and accountability framework. Although the precise workings of these features were outside the scope of this project, key considerations are discussed in Section 7 (measurement approach) and Section 8 (role of performance management frameworks, accountability structures and change programs in supporting improvements in patient experience).

The following figure outlines the key international frameworks considered, and the patient centric approaches that have been reviewed in mapping the priorities.

6.1 National and DHB indicators of Patient Experience

The establishment of domains of New Zealand patient experience will serve to define the priorities for the development of indicators. There are several considerations that must be kept in mind in the development of the indicators. These include the delineation between patient satisfaction and patient experience, the burden of measurement of indicators and ensuring the indicators can be utilised for system changes in order to improve patient experience.

Patient experience versus patient satisfaction

In developing patient experience indicators, it is important to understand the move away from more traditional patient satisfaction surveys and data collection. Patient satisfaction is considered a multidimensional concept, and subsequently it can be difficult to determine the underlying factors in ratings of poor satisfaction. However, patient experience data additionally seeks to elicit information on what actually occurred to the patient, as opposed to the patient's evaluation of what occurred.

As a result of these issues, some methodological problems have been raised with satisfaction indicators which suggest results may be prone to bias or lack specificity. These may include some of the following consequences:¹⁴

- a limited understanding of what constitutes an overall satisfaction score due to different individual weightings on dimensions of elements of the experience
- the potential for overall scores, which tend to reflect high levels of satisfaction, to mask differences in patients' views on particular parts of their experience
- survey approaches may reflect issues identified by administrators or clinicians rather than what patients view as important to their experience
- systematic bias may be introduced to feedback associated with aged and socio-economic status, with older people and people from a lower socio-economic status being more likely to be more satisfied than younger people or people from a higher socio-economic background. Other differences may arise from differences in gender, ethnicity, clinical conditions and severity.

Patient experience questions involve asking patients to report their experiences of a particular service, clinician or specific part of their interaction with health care services.

Proposed domains and indicators have been developed to focus on patient experience. This is based on contemporary practices in measuring patient feedback and offers the following benefits over patient satisfaction indicators:

- 1) The avoidance of potentially artificially high positive responses by using factual questions about events and occurrences.
- 2) Reduction of subjectivity and other potentials for bias from differences in expectations or response tendencies. A patient satisfaction question might ask whether the patient was satisfied with the clinician's communication with them prior to their operation, whereas a patient experience question might ask how the clinician communicated with the patient prior to the operation and how would they

¹⁴ Aharony, L. and Strasser, S. (1993), 'Patient satisfaction: what we know about and what we still need to explore', *Medical Care Review* 50(1), pp.49-79, Carr-Hill, R (1992), 'The measurement of patient satisfaction', *Journal of Public Health Medicine* 14(3), pp. 236-49.

Draper, M. and Hill, S. (1995), *The role of patient satisfaction surveys in a national approach to hospital quality management*, Australian Government Publishing Service, Canberra.

Hall, J. And Dornan, M. (1998), 'Meta-analysis of satisfaction with medical care: description of research domain and analysis of overall satisfaction levels'. *Soc Sci Med* 27(6), p. 637-44,

Sitzia J, and Wood N. (1997), 'Patient satisfaction: A review of issues and concepts' *Social Science and Medicine*, 45(12), pp. 1829-43,

Williams, B. (1994), 'Patient satisfaction: a valid concept?' *Social Science and Medicine*, 28, pp. 509-516.

Cited in Pearse J (2005) Review of patient satisfaction and experience surveys conducted for public hospitals in Australia. Available at www.pc.gov.au/gsd. Accessed on 26 April 2013.

evaluate that experience? In the patient satisfaction question, two patients might both rate being satisfied with different amounts of contact or different ratings of satisfaction for the same amounts of contact. The patient experience question would provide context for the satisfaction rating by understanding the frequency and type of communication from the clinician.

- 3) A greater ability to interpret and respond to feedback. Knowing that 25 per cent of patients were dissatisfied with their clinician's communication prior to the operation in a patient satisfaction question would provide fewer opportunities to identify improvements compared to a patient experience based question. A patient experience question would, in contrast, provide the precise details of what part of the communication process was not to the patient's satisfaction, such as the medium (telephone or face-to-face), message (appropriate use of language for the patient), or the timing (delivered too quickly), for example. Knowing the source of patient issues enables strategies to be put into place to more effectively improve patient care and experience.

Measurement burden

The success of any indicators relies, in part, on minimising the measurement burden, including the total time and effort required to populate the metrics. Measurement systems often fail due to the excessive administrative burden they impose. A key driver of measurement burden is the number of indicators; therefore, the total number selected should be restricted. These indicators should align with strategic priorities, should have sufficient sensitivity and specificity to identify issues and must be used to drive improvements in system.

Indicators proposed within the four domains need to be kept to a minimum in order to reduce measurement burden. Consideration should also be given to the measurement approach since collecting patient experience from different sources may also impose extra administrative burden. Indicators should also help to improve patient care and experience and act as an early warning of underlying issues.

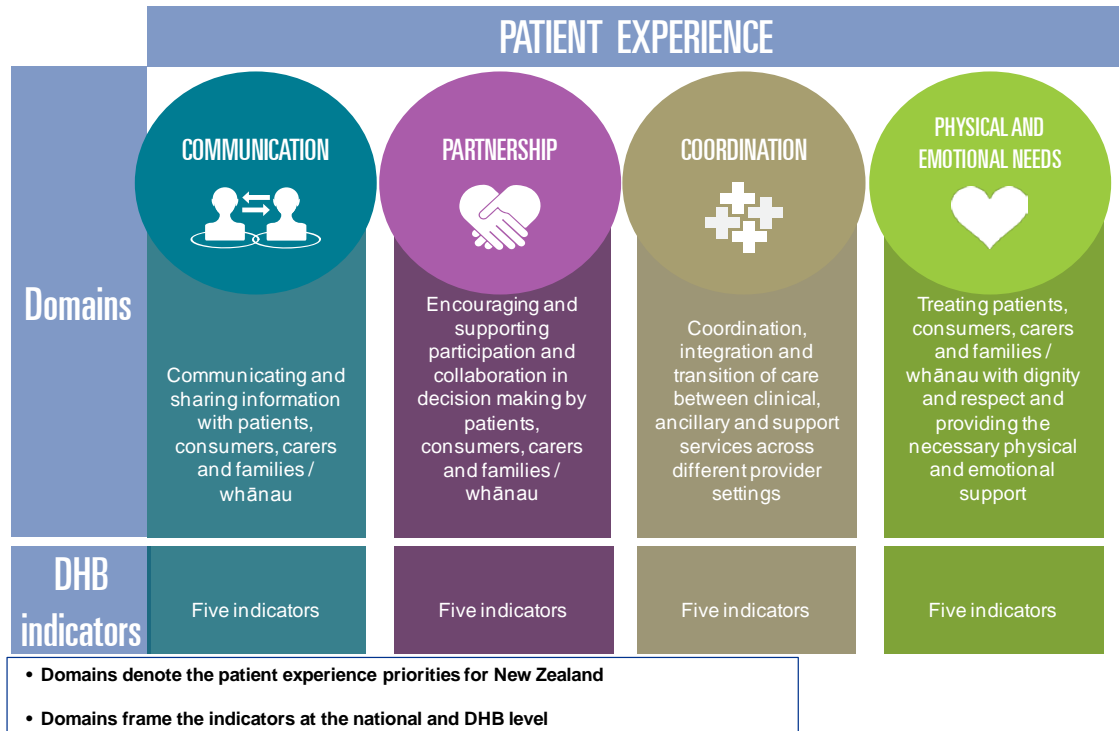
6.2 Recommended domains of patient experience and indicators

The intention of the domains of patient experience is to denote priorities at a national level. To ensure that measures drive the desired outcomes, it is critical that indicators are developed by identifying the key drivers, or factors that affect these priorities.

The four domains of patient experience for the Commission are listed below in Figure 6. In essence, what these four domains are saying is that a high quality experience for patients and consumers depends upon high quality and effective communications, a real partnership, excellent and seamless coordination of care and meeting both the physical and emotional needs of the patient.

Four domains have been selected on the basis of close alignment with current international best practice. Domains are supported by five recommended indicators that should be measured nationally and at the DHB level. These indicators will be referred to as DHB indicators from this point forward since the indicators are identical and national measurement will be based on aggregating DHB performance. The five recommended indicators were selected to keep the number of measures at a minimum in order to reduce measurement burden. For completeness and transparency, we have also included additional indicators relevant to each domain that we feel are a lower priority. The relationship between domains and indicator drivers is illustrated in Figure 6. The four recommended domains are shown on the following page.

Figure 6: Recommended patient experience domains and national indicators



The four recommended domains for New Zealand are aligned to the Picker Principles with the exception of the Picker domain of access. Access has not been included as a core domain as this domain is already incorporated within the Commission’s Outcomes Framework in the access/timeliness system level indicators. The indicators listed under each domain reflect elements that international research has identified to impact the domains.

The four domains, and DHB indicators, were also tested in two workshops and via an e-questionnaire in order to seek feedback on the proposed measurement domains and DHB indicators. Feedback from these consultation exercises was supportive and useful to refine measures of patient experience. Specific feedback from the consultation exercise is outlined in section 6.3.

Domain 1: Communication



Effective communication has been identified as an extremely important part of the patient experience and a fundamental component of providing high quality health care. The way in which information is conveyed can be equally important as what is being conveyed. Patients who understand the information being conveyed to them are more likely to accept their health issues, understand the treatment options available to them, modify their behaviour and adhere to follow-up advice concerning their care. Communication also applies vertically and horizontally and across all levels within health services for the patient.

There is strong evidence demonstrating that improved communication reduces the risk of adverse events across all patient groups. In addition, patients with communication difficulties may be at higher risk for preventable adverse events.¹⁵ An additional component of effective communication within health care is the acknowledgement and resolution of complaints. The failure to listen and respond to patients' and relatives' complaints was identified as a key factor in failing hospitals¹⁶, including, most recently, at the Mid Staffordshire NHS Foundation Trust (FT). The Picker Principles also highlight the importance of complaints management as a component part of communication as a patient experience domain. They state that patients should be made aware of how to raise a concern related to patient safety and/or their care while they are receiving health care.

Communication elements are also defined within the NHS Quality Board Patient Experience Framework.¹⁷ This includes: communication, information and education on a patient's clinical status, progress, prognosis and processes of care in order to facilitate autonomy, self care and health promotion.

Communication is also part of the patient experience framework of the CAHPS in the US. Additionally, this indicator reflects the key elements of the patient communication

¹⁵ Bartlett G, Blais R, Tamblyn R, Clermont RJ, MacGibbon B. 'Impact of patient communication problems on the risk of preventable adverse events in acute care settings' CMAJ. 2008 Jun 3;178(12):1555-62.

¹⁶ Coulter, A., Fitzpatrick, R and Cornwell, J. (2009). 'The Point of Care Measures of patients' experience in hospital: purpose, methods and uses'. The King's Fund. Available at <http://www.kingsfund.org.uk/sites/files/kf/Point-of-Care-Measures-of-patients-experience-in-hospital-Kings-Fund-July-2009.pdf>. Accessed on 26 April 2013.

¹⁷ Department of Health (2012) NHS Patient Experience Framework. Available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/146831/dh_132788.pdf. Accessed on 31 May 2013.

process identified in (Boyd 2007). The importance of communication and information on patient experience is also cited in studies by Bruster (2008), Coates-Duton & Cunninham-Burley (2009), Coulter (2005), Cronin (2004) and Gerteis et al (2003).

Table 2: National indicator on communication

Domain 1: Communication: National Indicator
Communicating and sharing information with patients, consumers, carers and families/whānau
DHB level indicator drivers (Key elements identified as important to patients in order to affect organisation and individual health care change in relation to communication)
<ol style="list-style-type: none"> 1. Health care staff listening to questions and concerns 2. Sufficient information being provided for consent to treatment 3. Minimising contradictory or confusing information 4. Health care staff answering questions in a way that can be understood 5. Patients/carers/families/whānau experiencing ease in finding someone to talk to about their concerns <p>Other DHB indicators (Lower priority)</p> <ol style="list-style-type: none"> 6. Patients/carers/families/whānau understanding the process of making a complaint 7. Test results being explained in a way that can be easily understood 8. Patients/carers/family/whānau experiencing improved health literacy as a result of information provided 9. Patients/carers/families/whānau given sufficient opportunity to ask questions

Domain 2: Partnership



The focus on partnership in the literature is evident not only in relation to health care delivery, but in service planning. Several DHBs reported that patients and key consumer groups were active participants in service planning, including capital planning activities at an organisational and DHB levels. Involving patients, consumers, carers and families/whānau is an important component in patient centred care. There is some evidence suggesting that improved participation can lead to improved knowledge and understanding, better perceptions of risk, improved comfort with decisions and treatment adherence and high confidence and coping skills (Murray et al 2005; O'Connor et al 2009; Picker Institute Europe).¹⁸

This domain should also be seen in the context of what activities health professionals provide to improve patient-centred care. This includes both collaborative and participatory elements in the NHS Quality Board Patient Experience Framework:¹⁹

- Transition and continuity in relation to information that will help patients care for themselves away from a clinical setting, and coordination, planning and support to ease transitions and care planning.
- Welcoming the involvement of family and friends, on whom patients and service users rely, in decision-making and demonstrating awareness and accommodation of their needs as care givers.

The importance of participation on patient experience is also cited in studies by Coates-Duton & Cunningham-Burley (2009), Coulter (2005), Cronin (2004), Gerteis et al (2003) and Sizmur & Redding (2009).

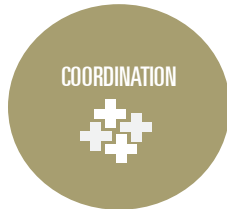
¹⁸ Kings Fund (2012) From vision to action making patient-centred care a reality. Available at http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/Richmond-group-from-vision-to-action-april-2012-1.pdf. Accessed on 31 May 2013.

¹⁹ Department of Health (2012) NHS Patient Experience Framework. Available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/146831/dh_132788.pdf.pdf. Accessed on 31 May 2013.

Table 3: National indicator on partnership

Domain 2: Partnership: National Indicator	
Encouraging and supporting participation and collaboration in decision making by patients, consumers, carers and families/ whānau	
DHB level drivers (Key elements identified as important to patients in order to affect organisation and individual health care change in relation to partnership)	
1	Patients/carers/families/whānau experiencing the opportunity to participate in health care service planning
2	Patients/carers/families/whānau actively participating in the development of treatment plans with their provider over the past 12 months
3	Patients/carers/families/whānau being involved in care planning where desired
4	Patients/carers/families/whānau experiencing sufficient involvement in decisions about health provision, as much as they wanted to be
5	Health care staff being responsive to a patient's desire to self-manage and otherwise be a partner in care where applicable
Other DHB indicator driver (lower priority)	
6	Patients/carers/families/whānau provided with information to enable the opportunity to share in the decision-making about their care

Domain 3: Coordination



Coordination of care is important to enable care to be organised around the patient's needs. When this is done well, the patient should feel that the care pathway and transfer of information is seamless. The benefits of improved coordination have been found to reduce emergency admissions in people with multiple chronic illnesses.²⁰ The Picker Principles identified that patients expressed feeling vulnerable and powerless in the face of illness and that coordination of care can ease those feelings.

A significant patient safety risk in the coordination of care is medication management. It is identified that points of transition for patients yield a set of challenges for safe medication use. According to the Institute for Healthcare Improvement, up to 46% of medication errors occur when new orders are written at patient admission or discharge. Changing a patient's clinical status or transferring a patient introduces new caregivers and creates the opportunity for misinterpretations or missed instructions.

Coordination is also incorporated in the NHS Quality Board Patient Experience Framework,²¹ which includes: *coordination and integration of care across the health and social care system*. Research by Boyd (2007) identified that doctors knowing enough about a patient's medical history was important to patient experience as was the finding by Cleary et al (1991) on the adequacy of time spent with patients by doctors discussing what to do at home in the context of the role of coordination in patient experience.

The importance of coordination on patient experience is also cited in studies by Bruster (2008), Coulter (2005), Gerteis et al (2003) and Sizmur & Redding (2009).

²⁰ Kings Fund (2012) From vision to action Making patient-centred care a reality. Available at http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/Richmond-group-from-vision-to-action-april-2012-1.pdf. Accessed on 31 May 2013.

²¹ Department of Health (2012) NHS Patient Experience Framework. Available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/146831/dh_132788.pdf.pdf. Accessed on 31 May 2013

Table 4: National indicator on coordination

Domain 3: Coordination: National Indicator	
Coordination, integration and transition of care between clinical, ancillary and support services across different provider settings	
DHB level drivers (Key elements identified as important to patients in order to affect organisation and individual health care change in relation to coordination)	
1	Patients/carers being informed of and understanding changes to a medication regime
2	Post discharge arrangements in a patient's home being considered prior to their discharge
3	Patients/carers/families/whānau being informed about which complications to be aware of at home
4	Patients/carers/families/whānau being made aware of who to contact with concerns when care episode complete
5	Patients/carers/families/whānau being provided sufficient information about hospital processes prior to admission (planned admissions)
Other DHB indicators (Lower priority)	
6	Patients/carers/families/whānau being advised of and understanding the role of each health care provider involved in an episode of care
7	Patients/carers/families/whānau understanding why a transfer to a different provider setting has occurred

Domain 4: Physical and emotional needs



Research demonstrates that the level of physical comfort patients report has a tremendous impact on their experience. From the patient's perspective, physical care that comforts them, especially when they are acutely ill, is one of the most elemental services that caregivers can provide. Hospital and health service surroundings and environment impact on patient experience, and factors for consideration include: ensuring that the patient's needs for privacy are accommodated and that patient areas are kept clean and comfortable, with appropriate accessibility for visits by family and friends.

Physical and emotional support is linked with the practical outputs of collaborative and integrated relationships between, and within, health care providers. Improving support has been found to improve a person's ability to adopt healthier behaviours and to improve their ability to self manage conditions. This, in turn, may reduce stress or anxiety and assist people undertaking everyday functions, such as working or travelling, without the need for care and treatment in nursing homes.²² Research by Boyd (2007) identified that doctors and nurses washing hands in between touching patients and the cleanliness of rooms and wards was important to the patient experience.

The evidence for this domain, like other domains, is based within the Picker Principles, and also incorporated in the NHS Patient Experience Framework and the US CAHPS. Within the NHS Patient Experience Framework, physical and emotional elements of need include: *respect of patient-centred values, preferences and expressed needs, including: cultural issues, the dignity, privacy and independence of patients and service users, an awareness of quality-of-life issues; and shared decision making. Physical comfort including pain management, help with activities of daily living, and clean and comfortable surroundings. Emotional support and alleviation of fear and anxiety about*

²² Kings Fund (2012) From vision to action making patient-centred care a reality. Available at http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/Richmond-group-from-vision-to-action-april-2012-1.pdf. Accessed on 31 May 2013.

such issues as clinical status, prognosis, and the impact of illness on patients, their families and finances.²³

The importance of physical and emotional needs on patient experience is cited extensively. This includes references in studies by Bruster (2008), Coates-Duton & Cunningham-Burley (2009), Coulter (2005), Gerteis et al (2003) and Sizmur & Redding (2009).

Table 5: National indicator on physical and emotional needs

Domain 4: Physical and emotional needs: National Indicator	
Treating patients, consumers, carers and families with dignity and respect and providing the necessary physical and emotional support	
DHB level drivers (Key elements identified as important to patients in order to affect organisation and individual health care change in relation to physical and emotional needs)	
1	Patients experiencing regular assessment and addressing their physical needs
2	Health care staff being available to discuss anxieties and fears of patients/carers/families/whānau
3	Patients/carers/families/whānau being treated with respect and dignity by health care providers
4	Health care staff attending to the patient's personal values, choices and needs
5	Patients/carers/families/whānau experiencing respect in relation to their spiritual beliefs
Other DHB indicators (Lower priority)	
6	Patients/carers/families/whānau being treated with compassion during the delivery of health care
7	Health care staff responding quickly to the needs of patients
8	Patients/carers/families/whānau experiencing empathy with their emotions and actual situation
9	Patients/carers/families/whānau experiencing the availability of space and time for both quiet contemplation and communal worship
10	Health care staff maintaining and respecting patient's privacy
11	Patient's carers, families/whānau being made comfortable
12	Health care staff allowing patients to define 'family' in relation to their care planning and visiting
13	Health care staff asking patients to identify family members or other support people who will participate in their care

²³ Department of Health (2012) NHS Patient Experience Framework. Available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/146831/dh_132788.pdf. Accessed on 31 May 2013.

6.3 Feedback from consultation workshops and e-questionnaire

In order to seek feedback on the proposed measurement domains and indicators, two workshops were held on Thursday, 12 June 2013, the first at Auckland and a second at Wellington. This was supplemented by an e-questionnaire for people who were unable to attend the workshops. The workshops were attended by 61 people, of whom approximately one quarter participated via teleconference. Twelve individuals responded to the e-questionnaire.

Areas of agreement

Feedback from workshop and e-questionnaire participants was very supportive of the four domains proposed. It was reported that these domains reflected important aspects of patient experience and were broad enough to allow a range of specific indicators to be selected to meet the needs and priorities of health services. The strong support confirms the appropriateness of the domains in the New Zealand setting, though further consultation and potential refinement is recommended.

Questions of clarification

While the support of the measurement domains was high, feedback from the consultation exercise raised the following points of clarification. The table below lists these questions with KPMG's response within the context of this project.

Table 6: Questions of clarification from consultation exercise

Feedback	Recommendation
<p>How will specific groups be measured?</p> <p>Will indicators with different levels of importance to patients be able to be accommodated?</p>	<p>Measurement considerations are discussed in section 7. This includes sampling approaches for identifying responses from specific groups, such as chronic patients, weighting options for standardising responses and potentially allowing patients to prioritise what measurement indicators/questions are important to them.</p>
<p>How will measurement be applied outside of the acute sector?</p>	<p>It will be essential for patient experience to be measured across the care sectors and this will need to be addressed as an implementation consideration. See section 9.</p>
<p>How will access to health care be measured?</p>	<p>Access to health care remains an important aspect to high quality care. It is understood that access indicators will be assessed separately to patient experience under the system level indicators of the Commission's Outcomes Framework.</p>
<p>Will the measurement approach incorporate patient outcomes?</p>	<p>Patient outcomes represent an important part of measuring high quality care and patient experience.</p>

	This project recommends that patient outcomes are considered by the Commission as an important supplement to collecting information on patient experience. This is referenced in section 9.
What will be the role and resourcing requirements of DHBs? Will an external body to collection information be considered to reduce the potential for DHB bias?	Detailed roles and resourcing decisions are outside the scope of this project, however key considerations are included in section 9.

There were also questions relating to how the domains and DHB indicators would be used to drive performance improvement. This has been discussed in section 8.2.

Suggestions for further improvement

Based on the feedback, we also acknowledge the importance of the following concepts and suggestions for further improvement. These have been incorporated in this report, unless stated otherwise.

- importance of the role of family/whānau and carer
- inclusion of health literacy
- survey questions and indicators to be consistent with the Code of Rights
- coordination should be both vertical and horizontal
- process indicators should be separated from experience indicators
- concepts of ‘understanding’ should refer to both staff and the patient
- consider using compliments as well as complaints. This has not been incorporated in the indicator list since there was also consistent feedback to reduce the number of indicators
- the wording of questions will need to be tested to ensure understanding by patients/carers and be tailored to match New Zealand culture.

Prioritisation of DHB indicators

DHB indicators have been listed in order of priority based on feedback from workshops and the e-questionnaire. Prioritisation should be reviewed with further consultation given that this list may not be representative of all stakeholders and this reflects feedback from the consultation exercise which suggested that there were too many indicators listed. A shorter indicator set also facilitates a clearer measurement approach, providing that core aspects of what is important to patient experience are included. The five DHB indicators per domain should be clarified with further consultation.

7 Measurement options for recommended indicators

7.1 Recommended measurement approach

It is recommended that the construction of indicators is based on individual survey questions asked directly to patients, or indirectly through a carer, relative/whānau or nominated friend. The question should be structured using contemporary methods of assessing patient experience, rather than satisfaction. Surveys should be available online, in paper form and other media, including translated versions for non-english speakers.

Aggregating indicators

A common approach to managing a number of indicators, such as survey based questions, is to create hierarchies. It is recommended that this approach is employed to populate DHB indicators, which in turn should be aggregated to provide a single indicator for each of the four domains. This approach is valid since each domain is based on lower level indicators and survey questions share the same concept. Aggregation will also apply to national indicators, by summing DHB indicators.

It is important to recognise that the aggregation of indicators may balance experience ratings and therefore mask poor performance at lower levels. For this reason, whilst aggregated indicators up to a domain level are recommended, DHB indicators and responses to survey questions should also be reported and monitored.

One single overarching indicator, based on the aggregates of the four domains (which are in turn aggregates of DHB indicators) is methodologically feasible. Providing survey questions are weighted by patients in terms of what is most important to them, the relative importance of indicator drivers and domains would also be carried through to a single overarching indicator. A major advantage of one aggregated indicator is its simplicity, which means that it can be easily interpreted. However, as a consequence, one aggregated indicator may lack specificity in detecting changes in constituent areas if lower level indicators are not assessed concurrently.

An overarching indicator could also be based on a single question, separate to the domains, such as “Overall how would you rate your experience of care?” Unlike an overall indicator based on aggregates of the four domains, this would not enable the ability to ‘drill down’ to lower indicator levels. For example, the aggregated approach to a single overarching indicator would enable experience scores to be investigated at the overall level, then by domain indicators, which in turn could be investigated by the contribution of the DHB indicator drivers and ultimately to survey questions. The separate single question would therefore not provide the ability to investigate which elements of the domains were contributing to changes of the overall indicator score.

A benefit of a separate single question is the potential for it to identify elements of the patient experience not captured within the survey questions and domain framework.

This would be highlighted by inconsistent scores/ratings. For example, domain indicators may all be very positive (9/10 each) but the overall experience indicator could be less positive (7/10). This situation is illustrated below in the case study from Marks & Spencer, a major British multinational retailer specialising in clothing and luxury food products in the UK.

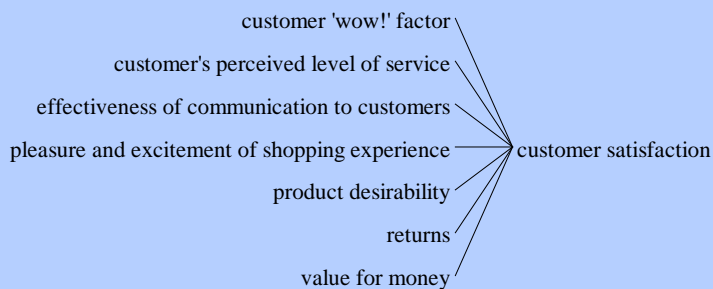
An illustration of the need to measure drivers plus the desired outcome. Marks & Spencer (M&S) customer satisfaction

The figure below sets out the high impact factors or drivers that M&S identified as the most critical factors that affect customer satisfaction. The measurement framework therefore included seven measures to track these seven drivers.

M&S also designed a question to ask customers directly, *'how satisfied are you?'* What emerged was that, while the seven drivers were all positive and hit their targets, so reported as 'Green', the direct customer satisfaction measure was lower than expected and reported as 'Amber'. What this meant was that the assumption that these are the key drivers of satisfaction was wrong. Something was missing. Further research indicated that the customer's ability to find the product was absent.

Once this was added in, there was a match between the rating of all the drivers and the resulting score for the overall customer satisfaction outcome. Measuring both the drivers and resulting outcomes, or incorporating this in cognitive testing, is therefore a good principle to adopt as it can act as a logic check.

Figure 7 High impact drivers of customer satisfaction: Marks & Spencer



The above example illustrates the importance of ensuring that the domains address what is most important to patient experience and that the survey questions, through cognitive testing, adequately measure the scope of the domains. These activities, as undertaken by Marks & Spencer, should mitigate the potential for inconsistency in what is being measured to what is important to patients.

Additionally, the survey should provide an opportunity for open ended, qualitative responses to identify other feedback not elicited in the main question set.

In addition to the above points, it should be noted that there is a tendency for overall rating questions to produce mildly positive scores. Differences in scores may, for instance, be due to factors unrelated to the content used to answer the overall rating and content assessed within the domains.

An important factor in developing robust aggregates is for each component to relate clearly to the aggregate indicator and for this to be receptive to changes in the appropriate direction. For example, some questions differ in terms of how they are framed, either as positive or negative statements. Given a consistent response scale, interpretations of a rating scale of 'most of the time' would have a completely different meaning when interpreted in the context of a good or bad patient experience (ie. "I felt listened to" versus "the doctors talked as though I was not there").

Aggregation is used both in Australia, in the Victorian Patient Satisfaction Monitor (VPSM), and the UK where indicators are within the patient experience domain of the NHS Outcomes Framework. The workings of these measurement frameworks are described in section 8.2.

Mapping patient experience indicators to individual providers

The survey approach will make mapping patient experience indicators to individual providers possible. It is recommended that this should be considered as a future opportunity. Given the increase in the sample size necessary to collect representative information on individual providers the cost and benefits of this option will need to be appraised by the Commission. The appraisal should be completed with reference to alternatives to gather information on individual providers relating to patient experience, such as patient outcome reporting, for example.

7.2 Measurement options

A summary of measurement options are described in this section. These should be read in conjunction with the recommendation of a patient survey. For completeness, measurement options which do not comprise the recommend approach are also included in this section.

Representativeness

In order for the national indicators to be compared, it will be necessary for each indicator to be representative of the patient population. Representativeness principally means having a sufficient number of patients (sample) from the total population plus the application of appropriate statistical techniques, such as weighting to correct for disproportionality of the sample relative to the population. This may include age or gender, or level or type of illness, for example. It is recommended that statistical advice is sought in order to inform decisions on weighting and other statistical methodological issues.

Options on how and when to collect patient information on indicators

There are three options available when deciding when to measure patients' experiences. These include at the point of contact (in hospital/at the service provider), post treatment or continuously.²⁴

At point of contact

Post treatment, or exit, surveys may be administered upon the patient's exit from hospital or after a period of care has elapsed. Methods can include written responses to questionnaires or comment cards. Alternatively, methods to elicit survey responses may be electronic and include hand held devices, kiosks or bedside terminals, for example. Some common problems associated with post treatment patient feedback include:

- the fitness of the patient, since many patients may be too ill to participate in the feedback process
- an inability to measure the complete patient journey since the patient will not have experienced post discharge care arrangements
- the potential bias from administration by staff of the healthcare organisation, which may mask negative responses. This potential problem may be mitigated by the use of volunteers and clear communication that responses will remain anonymous.

Post treatment

Options to assess patient feedback post treatment include mail, telephone or online surveys, face-to-face interviews, focus groups or patient panels. Unlike at point of contact feedback, post discharge arrangements can be assessed and any potential for bias from administering the survey within the health care setting, either by employees of the organisation or volunteers, is reduced. Additionally, the patient will have had some time to reflect on their care and recovery such that they may be in a better position to provide feedback. The timing of when to request feedback needs to be balanced between ensuring that patients have had an opportunity to recover sufficiently and to reflect on their experiences but for their experiences to still be current, both for recall of their care experience (*what happened*) and emotional response (*how they felt*). The use of at least two reminders is viewed as good practice in order to promote a good response rate (above 40 per cent) to self-completed mail or online surveys. This may mean that the response period could be up to six weeks if the survey was administered at two weeks following the patient's discharge.

²⁴ Coulter, A., Fitzpatrick, R and Cornwell, J. (2009). 'The Point of Care Measures of patients' experience in hospital: purpose, methods and uses'. The King's Fund. Available at <http://www.kingsfund.org.uk/sites/files/kf/Point-of-Care-Measures-of-patients-experience-in-hospital-Kings-Fund-July-2009.pdf>. Accessed on 26 April 2013.

Continuously

Patient diaries may represent one of the most complete pictures of assessing patient feedback since they present a complete picture of the patient's care journey. However, they are very time consuming for the patient to complete and also for the hospital/third party to analyse the results. Further, since a patient diary is dependent upon adequate literacy, they may not be appropriate for some patient cohorts. Alternatives include administering surveys along different parts of the patient pathway. The internet offers the ability for patient feedback to be collected, though unlike surveys in which respondents are chosen using appropriate statistical techniques from an eligible patient pool, there is no way of assessing the representativeness of responses and therefore there is an inability to benchmark or assess changes over time. Notwithstanding these comments, the medium represents a rapid way of collecting feedback.

Design options

The design approach to collecting information on patient indicators should be aligned with the purpose for which the information will be used since the design approach may dictate certain methodologies.

Since national indicators will require comparability and potentially the ability to measure indicators on a trend basis, the measurement approach will require consistency in cohorts of patients selected, as well as other attributes which favour quantitative over qualitative approaches. Testing whether activities are having their designed impact on the patient experience may require a greater frequency of assessing patient feedback or, if a particular patient cohort is to be tracked, routine data or observations could be the appropriate design approach.

Weighting feedback for patient preferences

Within a survey methodology, individual questions may be weighted by patients to reflect what is most important to their experience. This approach is ideally suited to when indicators are aggregated across a range of measures or domains since overall measures of patient experience will reflect the weighted domain scores. This is intuitively appealing given the fact that the relative importance of indicators or domains is selected by the patient. The relative importance of indicators or domains can be based on a series of scales with areas of higher importance to the patient receiving a higher weighting in the aggregate indicator(s).

Quantitative approaches

Quantitative methods are concerned with numerical data outputs and that are appropriate for statistical analysis. These methods enable the analysis of responses from large samples to report on the differences or consistency of responses to each question answered, including sub groups – where statistically valid. Where appropriate methods are used over time, quantitative approaches enable comparisons to be made

between periods and also on the significance of the change. Responses to quantitative approaches generally restrict responses by including only predetermined categories. This means that some depth in responses may be lost where response categories do not reflect the breadth of response possibilities of all respondents.

Common examples of quantitative methods for seeking patient feedback include the following:

- postal surveys
- interviewer administered face-to-face surveys
- interviewer administered or automated telephone surveys
- online surveys
- surveys held on other mediums, such as hand held electronic devices or other consoles, touch-screen kiosks, pre-existing administrative functions.

Qualitative approaches

Qualitative methods are focused on providing greater depth in selecting patient feedback. This is achieved by an emphasis on words rather than numbers/ predetermined response categories as options for collecting feedback. This enables a much greater level of detail and potentially insights into issues than quantitative methods but without the ease of making comparisons between the survey and over time.

Common examples of qualitative methods for seeking patient feedback include the following:

- face-to-face interview (in depth)
- focus groups
- discovery interviews led by clinical staff
- free comments from websites, comments cards or suggestion boxes
- video boxes (on-site)
- complaints and compliments programs
- patient diaries
- direct observation (mystery shopper)
- customer (patient) journey mapping.

Qualitative methods can be overly expensive to coordinate at a national level for indicators required to be representative across services in order to enable comparison. It is recommended that qualitative methods be employed only for those indicators where information does not need to be representative and/or compared on this basis.

Qualitative methods should be encouraged to support the overall measurement approach and to focus on priority areas highlighted by the national survey or identified through other means.

Quantitative sampling approach

Sampling refers to selecting a subset of individuals from within a population, such as total number of patients being treated within a healthcare organisation in a given time, to estimate characteristics of this patient population. For the sample to be useful, it must be representative of the population from which it is drawn. This involves an accurate:

- Survey population: consumers whose feedback is required.
- Sampling frame: complete listing of the people whose feedback is required. This should exclude people outside the scope of the survey either due to their age or non-representativeness. This should also exclude deceased patients, where the survey is to occur post discharge, to avoid distressing family members who ultimately will receive the invitation to participate in the survey.
- Sample: selected individuals from the survey population who will be invited to participate in the survey.

It is recommended that all indicators needing to be representative be collected using a quantitative sampling approach. From the sample, there will be a response rate indicating the percentage of people from the sample who completed the survey. This rate and the approach to selecting the sample require the application of appropriate statistical methods in order to ensure that the process minimises sampling error and produces a statistically representative set of information from which to use to investigate patient feedback. Guidance may also need to be sought on obtaining the appropriate approval of methods employed with respect to ethics, data protection/ security and other guidelines/requirements. The wording of questions should also be consistent with the Code of Rights.

7.3 Timing

Timing of surveys and communication with patients

The potential timing issues with respect to the frequency of the survey is discussed in section 9. It is common for patients requested to participate in patient surveys to receive up to three survey related communications. These may include the following approaches:

1. **Initial correspondence:** Each selected patient receives a questionnaire pack including a personalised covering letter, relevant questionnaire and reply-paid envelope. Patients could also be offered a unique username and password to complete the survey online. Further, patients may receive a Language other than

English sheet that explains the nature of the survey in the most frequently used languages in the jurisdiction.

2. **Reminder letter:** A reminder/thank you letter is commonly sent to all selected patients to encourage participation. This letter could thank patients who may have already completed the questionnaire. Patients could again be offered a unique username and password to complete the survey online.
3. **Final correspondence:** Patients who have not returned the questionnaire, completed it online or opted out of the survey would normally receive a second questionnaire. Each selected patient would receive a questionnaire pack including a personalised covering letter, relevant questionnaire and reply-paid envelope. Similar to other correspondence stages, patients could also be offered a unique username and password to complete the survey online.

A summary of advantages and limitations of measurement approaches has been provided in Appendix D.

Potential data considerations

As discussed in previous sections, quantitative and qualitative approaches used to underpin patient experience indicators may be sourced from a variety of different methods. Indicators sourced directly from patient feedback, require direct patient feedback as the source and the key issues relate to how the feedback is collected from surveys and other direct response mechanisms and have been described previously. Data considerations may include some of the following:

- **Data source:** The source of the data for the indicator should be described.
- **Data aggregation:** The indicator should outline how data will be aggregated and whether, similar to survey approaches, any risk adjustment will be applied. Risk adjustment may be appropriate to account for differences in patient characteristics, such as age or gender, or level or type of illness.
- **Data quality (availability, completeness and accuracy):** The indicator should also ensure that the information used is based on information that is readily available, complete and accurate. There should be clear guidance on how the indicator will manage data quality, specifying conditions under which data will be and will not be used. Where data quality is poor, indicators may be constructed to assess data quality;
- **Data continuity:** If the indicator is to be used over time, it will be important to ensure that data sources will continue to be available. Any change to source data will need to be noted so that differences do not introduce bias into the indicator.

8 Linking patient experience measurement with strategy and improved health outcomes

8.1 Relationship to broader measurement framework

Measuring patient experience indicators is not sufficient in order to improve the patient experience. Despite a range of patient feedback options being available to organisations, not all have adequate systems for using the information in a performance management framework. An effective performance management framework needs to formalise regular monitoring and reporting within the organisation, set clear responsibilities for using the information, include triggers to act on exceptions and have appropriate governance arrangements to enable and ensure that senior leaders and board members drive performance.

Openness and transparency throughout the system, developing and sharing measurement and understanding individuals' performance, team, unit and provider organisation performance were some of the key focus areas for recommendations of the Public Inquiry into Mid Staffordshire NHS FT by Robert Francis QC.²⁵ This high profile inquiry followed the publication in 2009 by the Healthcare Commission on the severe failings in emergency care provided by Mid Staffordshire NHS Foundation Trust between 2005 and 2008. Specific recommendations included: clear lines of responsibility supported by good information (*recommendation 142*), clear metrics on quality (*recommendation 143*) and ownership of quality metrics at a strategic level (*recommendation 144*). The strategic ownership of quality metrics referred to the development of indicators on quality and outcomes of care to be used throughout the health care system, from commissioners of health care management to health care providers' performance.²⁶

As previously stated, the Commission should undertake further work to ensure appropriate linkages to the health system strategy and priorities and overarching policy frameworks to clarify the outcomes sought in relation to patient experience. Some of these considerations are explored in the following section (8.2).

²⁵The Mid Staffordshire NHS Foundation Trust Public Inquiry (2013). Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry Executive summary Available at <http://www.midstaffspublicinquiry.com/sites/default/files/report/Executive%20summary.pdf>. Accessed on 3 May 2013.

²⁶ The Mid Staffordshire NHS Foundation Trust Public Inquiry (2013). Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry Executive summary Available at <http://www.midstaffspublicinquiry.com/sites/default/files/report/Executive%20summary.pdf>. Accessed on 3 May 2013.

8.2 Accountability

An important objective of this project was to enable the Ministry of Health to uphold and strengthen accountability by measuring patient experience in DHB funded services. In this context, the following points have been identified for consideration by the Commission and Ministry, whilst recognising that further work will be required to form and test any new accountability arrangements.

The accountability framework should answer the following questions. These questions were also raised by some participants in the consultation exercise conducted in order to seek feedback on the proposed measurement domains and indicators.

- What are the objectives of the accountability framework?
- How will the accountability framework operate, including
 - the methodological approach to form the assessment
 - roles and responsibilities of stakeholders in assessing performance
 - actions, penalties or incentives associated with poor performance?
- How will the accountability framework ensure measuring patient experience actually drives performance improvement? What will success look like?
- How will measuring patient experience fit within other measurement frameworks?
- What reports will be generated and will consumers be able to access the information or report back to the community and consumers explicitly?

Principles

The first principle is that it is only reasonable to be led to account for areas that are broadly inside one's sphere of influence. Effective accountability frameworks are an essential component of supporting improvements in patient experience. Accountability arrangements should be defined in an overarching performance management/accountability framework showing how individual indicators are used to derive national indicators, and how these will be measured and used by the Ministry of Health. This could be driven predominantly from the four domains.

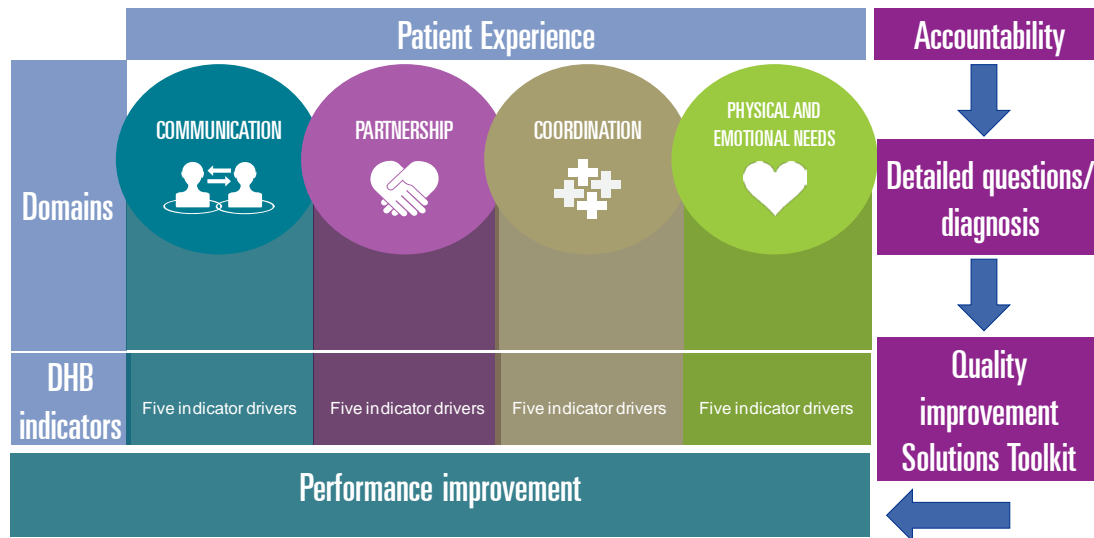
Accountability arrangements should support:

- showing the health system's performance on patient experience
- enabling patient experience to be linked with and inform broader strategic directions of health care in New Zealand and to be embedded in the system of delivery of care.

As shown in Figure 8 below, assessment at a domain level could form the basis for accountability; however, detailed questions used to populate DHB indicators could be

used to drive performance improvement. These lower level indicators could act as the diagnostic to understand the cause and identify corrective actions.

Figure 8: Relationship between domains and accountability framework



Linking patient experience domains with indicators, strategy and improved health outcomes

The use of a framework ensures that indicators are linked with issues identified as a priority for patients. The patient experience domains require *what matters to patients* to be at the centre of measurement; therefore, supporting indicators should be framed as a measure of improved patient experience, rather than other professional or service improvements. A framework also enables the patient experience to link with, and inform, broader strategic directions of health care in New Zealand and to be embedded in the system of delivery of care.

There are also broader system benefits to the use of patient experience domains. These include opportunities to create and embed improvement and accountability structures across all levels of the health system. Opportunities include:

- Building stronger performance management frameworks at DHB and service levels to encourage and empower organisations to further develop their own complementary indicators and use a range of innovative approaches to measurement, including at the national and patient level. This could, for example, include qualitative approaches such as patient focus groups, diaries and message books.
- Creating transparency and accountability structures for national indicators by considering publishing results in order to assist patient choice, and by embedding performance improvement in financial and operational contracts. An example of this is in the UK where the NHS seeks to incorporate all of these options by

publishing the results of patient surveys on NHS Choices, setting improvement plans and targets against patient experience indicators and, for some of these indicators, issuing financial incentives and penalties based on meeting or failing to meet agreed standards.

- Investment in change programs to deliver significant improvements in patient experience. For example, the Cleveland Clinic in the US invested heavily in improving its patient experience following relatively poor satisfaction scores in the Centres for Medicare and Medicaid Services (CMS) Consumer Assessment of Healthcare Providers and Systems Survey (CAHPS).²⁷ Key activities included creating a new position, a chief experience officer and Office of Patient Experience resourced to include project managers, data professionals and service excellence trainers to conduct a comprehensive, internal program of measuring patient experience. Additionally, the Cleveland Clinic embedded a culture of all staff being responsible as caregivers and change agents. This supported embedding the cultural changes and created a focus to continue to concentrate on identifying and correcting problems. Since the investment in change commenced, performance in the CMS survey improved to within the top 8 per cent of approximately 4,600 hospitals. This significant turnaround highlights that improvement may not be simple and is certainly more complex than measuring patient experience alone. This reinforces the earlier statement on the need to spend more time using information to improve patient experience than in collecting and analysing information for only measurement purposes.

What could an accountability framework look like? Examples from other jurisdictions

A review by Nuffield Trust on rating providers to the Secretary of State for Health in the UK suggested that a system of provider ratings could act to improve accountability for the quality of care. This recommendation assumed that ratings were simple, valid and had a wide span of reporting.²⁸ The review found that ratings have been found to have a positive effect on improving the performance of providers, to the extent that the measures accurately reflect quality. Benefits were predicted to be higher for social care and general practices since choice is more of an option to consumers in these sectors.

Potential disadvantages of provider ratings in the evaluation noted the potential for perverse incentives to be introduced by focusing on measures being rated and away from measures not being rated. The level of the perverse incentive was found to be

²⁷ Merlino, J and Raman A (2013) 'Health Care's Service Fanatics' Harvard Business Review. Available at <http://hbr.org/2013/05/health-cares-service-fanatics/>. Accessed on 24 May 2013.

²⁸ Nuffield Trust (2013) 'Rating providers for quality: a policy worth pursuing?' *A report for the Secretary of State for Health*. Available at <http://www.nuffieldtrust.org.uk/publications/rating-providers-quality>. Accessed on 18 June 2013.

related to the level of sanctions that result from the rating. It was recommended that any rating system dovetail within existing performance management systems.

A necessary first step is to define the role of the accountability framework, including its relationship to other objectives of measuring patient experience. Common reasons for setting up accountability frameworks include to:

- increase accountability to the public, users, commissioners of care to Parliament (for publicly funded care)
- aid choice
- improve performance
- identify and prevent failures in the quality of care
- provide public reassurance as to the quality of care.

Examples from Victoria, Australia, and the NHS, UK

NHS

A feature of the NHS is the degree to which patient experience indicators are formally built into accountability frameworks which embed measurement and actions within the NHS at a sector level and organisational level since indicators should be built into contracts between Clinical Commissioning Groups (CCGs) and healthcare providers. This allows for further investigation of high level indicators at local levels, and the flexibility in applying potentially varied approaches to demonstrate that patients are being listened to and that their feedback is acted upon.

This is enshrined in the following key operating models, frameworks and policies governing the NHS:

- **NHS Operating Framework:** The NHS Operating Framework 2012-13 specifically states that the NHS should collect and use patient experience information in real time and use it for service improvements: "NHS organisations must actively seek out, respond positively and improve services in line with patient feedback. This includes acting on complaints, patient comments, local and national surveys and results from 'real time' data techniques".²⁹
- **NHS Outcomes Framework:** The purpose of the NHS Outcomes Framework is to provide a national level overview of how well the NHS is performing, to provide an accountability mechanism between the Secretary of State for Health and the proposed NHS Commissioning Board, and to act as a catalyst for driving quality

²⁹ Department of Health (2012) The NHS Operating Framework. Available at <https://www.gov.uk/government/publications/the-operating-framework-for-the-nhs-in-england-2012-13>. Accessed on 18 June 2013.

improvement and outcome measurement throughout the NHS by encouraging a change culture and behaviour.

The NHS Outcomes Framework is structured around five domains, which set out the high-level national outcomes that the NHS should be aiming to improve. Under each domain, there are a number of overarching indicators followed by improvement areas at a sub-national breakdown (regional, CCG level, local authority and provider) and equality and inequality strands at a national level (deprivation area, socio-economic group, age, ethnicity, religion or belief, gender, disability and sexual orientation).³⁰ One of the five domains relates to patient experience. This is further broken down into improvement areas.

The Department of Health uses the existing national surveys to provide data for each domain, though the Operating Framework recommends that patient feedback activities should be undertaken in addition to the annual survey to support patient improvement activities.

Victorian health service performance monitoring framework

In Victoria, Australia, patient satisfaction/experience surveys are funded by the Department of Health and formally built into accountability frameworks.³¹

The Victorian Health Service Performance Monitoring Framework (VHSPMF) describes the mechanisms used by the Department of Health to monitor health service performance. It outlines the key outcomes, attributes and improvement priorities for the Victorian healthcare system. Amongst its seven priorities, the framework includes improving every Victorian's health status and health experience.

The Statement of Priorities (SoP) is the key accountability agreement between the Health Service and the Minister for Health. The SoP also specifies performance and activity targets to be achieved within the allocated annual budget across financial viability and access and quality of service provision. The agreed KPIs and activity targets in the SoP form the basis of health service performance assessments throughout the year and are also reported as part of the annual reporting cycle.

The Victorian Patient Satisfaction Monitor (VPSM), the existing statewide survey, comprises a subset of the measurement framework to assess hospital experiences.

³⁰ Department of Health (2013) The NHS Outcomes Framework 2013/14. Available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/127106/121109-NHS-Outcomes-Framework-2013-14.pdf. Accessed on 30 April 2013.

³¹ Department of Health (2011) Victorian health service performance monitoring framework 2011-12 business rules. Available at [http://docs.health.vic.gov.au/docs/doc/A07C60549F0D3BA0CA257930000B22C9/\\$FILE/VHSPMF-business-rules-2011-12.pdf](http://docs.health.vic.gov.au/docs/doc/A07C60549F0D3BA0CA257930000B22C9/$FILE/VHSPMF-business-rules-2011-12.pdf). Accessed on 18 June 2013.

The VPSM uses 25 grouped questions to derive six sub indices of care which is summed into an overall index. This acts as the global indicator for hospital experiences.

A minimum threshold is required for each campus within a health service to achieve the target. The target is scored at a possible five points for achievement or zero points for failure. Performance is monitored and assessed biannually and a performance assessment score is generated quarterly.

The global indicator for hospital experiences score (up to five points) contributes to a maximum score for a health service of 100 points within the overall framework, which is based on a range of finance, access and service performance indicators.

Accountability responses are triggered when a health service score falls below certain thresholds. This includes 50–69 points triggering performance monitoring and a score of fewer than 49 points triggering intensive monitoring. Scores of 70–100 continue standard monitoring arrangements.

Performance watch and intensive performance monitoring involve a heightened scope and frequency of monitoring, regular meetings with the Department and possible involvement by the Secretary of the Department, Minister and health services board Chair. Health services are also required to provide more detailed information than standard monitoring. Standard monitoring comprises quarterly meetings between the Department and individual health services to discuss performance.

8.3 Patient-centred care linkages to contracting

Patient experience indicators should also support patient-centred care in the context of funding arrangements. A common limitation of contracting is that providers receive little reward for delivering quality care and innovation. In fact, often these improvements result in decreases in revenue, and are therefore a disincentive to innovate and collaborate. To reward value in health systems, contracting and financing arrangements should be configured to support collaboration, high quality, efficient and patient-centred care. A contracting system that focuses on patient-centred values should incorporate patient experience and outcomes (such as PROMs). Benefits of a patient-centred approach would be expected to:

- increase the quality of outcomes of care delivery
- provide the optimal value of care delivery
- reduce the price of care delivered.

Measurement of patient experience and outcomes should be clustered around the disease/condition categories as opposed to simply the silo of a provider only focus. This is an important concept and part of broader opportunity to pay providers to deliver high quality and innovate, rather than simply paying for services. More broadly, patient experience is part of a wider approach to improving the value of payment

arrangements of health services. Contracted services should make sense from the patient's point of view, from a clinical perspective and promote integration of services. This involves a clear definition and measurement approach to what patients and professionals aim to achieve in delivering care and enabling continuity of outcomes.

8.4 Relationship between national and local activities

In addition to the role of a national approach to improving patient experience, local activities should also be encouraged.

The role of a national approach to measure patient experience via a representative survey is necessary in order to form robust measures of patient experience and to use this as a basis to assess changes over time. This will inform both an accountability framework and improvement initiatives across health services.

Local activities should complement the national approach by developing innovative ways to measure and improve on the patient experience alongside, and in addition to, the national approach. For example, the national survey may identify an area of improvement which could be investigated further by local activities comprising qualitative approaches, such as focus group interviews, to understand more clearly the issues identified in the survey. These complementary methods may be drawn upon to design appropriate improvement strategies, which in turn can be assessed locally. Local monitoring may be preferable since it may not be appropriate to wait for the next national survey to assess the degree of change.

Local activities to complement the national survey could include the following methods:

- focus groups
- measuring complaints and compliments
- web-based feedback and feedback from other sources, such as social media
- comment cards, exit surveys and suggestion boxes
- iPad and kiosk feedback
- patient diaries
- mystery shopping, direct observation and patient journey mapping.

There are also opportunities to improve the patient experience by ensuring that policies and procedures give due consideration to how patients access services. This is particularly important for patients with physical or intellectual disabilities and people who face language or communication barriers, for example. Other examples could include developing a patient reference committee with representation on the health service's board and/or in areas which have the greatest impact on the patient experience.

There are many examples of local measurement activities undertaken using the above approaches, plus examples of innovative practices. This includes the University Hospital of South Manchester Trust, in the UK, which plans to be the first hospital in England to publish data on doctors. This includes information on national standards as well as what patients under their care have said about them. The purpose of the collection and publication of this information is to allow patients to pick their doctors based on their previous results.

This system was developed with assistance from the Picker Institute Europe. The initiative has drawn praise from Sir Donald Irvine, Chairman of Picker Institute Europe, and former President of the General Medical Council and support from the British Medical Association (BMA) which welcomes giving patients access to meaningful information. The BMA cautioned, however, that doctor outcomes are influenced by a range of factors. This includes different levels of patient complexity which impact on the likelihood of complications and that specialties have different ways of working which can lead to different results between craft groups.

9 Suggested next steps

This section identifies the activities or 'next steps'. It will be important to continue the momentum created by this project. The activities identified represent the priorities for the next six to nine months in order to achieve measures of patient experience by July 2014. This would require survey information to be collected from December 2013.

9.1 Resourcing considerations

Consideration should be given to the resourcing requirements to deliver the necessary measurement activities and support the functioning of a robust accountability framework. This will be dependent on the final measurement approach selected by the Commission and the role and responsibilities associated with implementation.

As outlined in section 7.1, it is recommended that the construction of indicators is based on individual questions asked directly to patients, or indirectly through a carer, relative/whānau or nominated friend. A survey approach will require designing a methodological approach, collecting patient eligible data sets, administering the survey, summarising the outcomes and linking to the defined accountability framework. It is likely that some of these activities could not be accommodated within the existing system without additional resourcing.

The level of resourcing may be once off, or time limited, in the case of developing a survey methodology and testing. It may be continuous for other activities, such as resourcing an accountability framework. Other activities may be absorbed within existing resources and budgets, such as developing eligible patient lists for the survey.

It will be important to clarify these resourcing considerations once the measurement approach and accountability framework are finalised.

9.2 Further consultation and tailoring for New Zealand

The consumer indicators and framework within which they sit are drawn from international best practices observed in the literature scan and from expert advice from the KPMG Global Health Centre of Excellence. The indicators have also been developed to be consistent with the priorities of the Commission, relevant to DHBs, and feasible to collect at a local level. This was informed by two consultation workshops held in Auckland and Wellington, discussions with the Ministry of Health and feedback from an e-questionnaire.

While the evidence base is robust and support from the consultation process was positive, it is recommended that further stakeholder consultation be undertaken to further test the appropriateness of DHB indicators and ensure best fit with New Zealand. Feedback from the consultation workshops included comments on the value of extending the consultation process, particularly to minority groups.

Consultation will also be an important aspect in developing the accountability framework once DHB indicators are finalised. The importance of stakeholder consultation was highlighted by Nuffield Trust's report on rating systems in the UK. The report recommended that the design and presentation of a rating system should be sector-led with groups representing the public and consumers of care involved.³²

³² Nuffield Trust (2013) 'Rating providers for quality: a policy worth pursuing?' *A report for the Secretary of State for Health*. Available at <http://www.nuffieldtrust.org.uk/publications/rating-providers-quality>. Accessed on 18 June 2013.

9.3 Survey considerations

Frequency of survey

The optimal frequency for a patient experience survey is driven by considerations of:

- **Quality of information:** The frequency with which a survey is performed results in any change in the quality of information, assuming consistent methodologies. However, surveys run at a greater frequency, provide more timely information and therefore provide several benefits to improving patient experience. These may include the following advantages:
 - timely information enables a faster detection of, and response time to, any potential issues compared to information which is less timely
 - regular surveys enable changes to be assessed more rapidly, meaning that responses can be evaluated as to their effectiveness
 - surveys that are run at more frequent intervals have a better chance of capturing issues related to specific periods, such as winter pressures, though this would need to be reflected in the method since weightings may be applied to provide a consistent basis for comparison, regardless of the timing of the survey.
- **Cost:** Increasing the frequency of a consumer experience survey represents a given cost each time it is performed.
- **Compliance burden:** Depending on the level of involvement of DHBs, there may be a compliance burden associated with supporting surveys. This would imply that the compliance burden would increase proportionately with the frequency of surveys. There is also a resource requirement for DHBs to review and respond to surveys which would also increase proportionately with the frequency with which a survey is run.
- **Local surveys and patient experience measurement approaches:** There is potential for some duplication of effort in surveys run at high frequency and DHBs which undertake internal patient experience measurement approaches. Some of these approaches may provide richer and/or real time information that complements the survey when run in between measurement intervals. If measurement intervals of patient surveys were too short, i.e. the survey was being run frequently; the added value may be diminished since core measurement activities of the DHB continue to measure the patient experience in meaningful ways.

The optimal frequency of patient experience surveys should therefore be based on due consideration of these dimensions. The international experience is varied, with the Victorian survey being undertaken monthly and results provided quarterly. This compares to the NHS where the national surveys are undertaken annually. It should be

noted, however, that health services are strongly encouraged, and indeed are expected, to measure consumer experience outside of the annual survey.

Conduct of survey: Tendering versus in house development

It is likely that the development of the survey methodology and its conduct will be tendered by the Commission to an appropriately qualified contractor. This may be necessary to avoid disruption to DHBs without the resources to support the survey. For example, it was reported that nurse managers were used to fill envelopes with surveys in the previous incarnation of the national survey. Contracting out administrative tasks will allow health experts to focus on the key tasks of analysing the results and determining the appropriate actions to improve performance.

Appropriate methodological support will be necessary to ensure that the questions underpinning the survey are robust and cognitive tested. It is suggested that due consideration be given to the advantages offered by enabling patients to indicate which domains or indicators are most important to them when completing the survey so that responses can be weighted.

Cognitive testing would identify if respondents understand survey questions and answer questions correctly. This process helps to improve overall data quality. Cognitive testing can also provide benefits after the survey has been completed by adding a greater level of understanding of responses, including identifying questions most likely to be subject to response error. The wording of questions should also be consistent with the Code of Rights.

The design of the survey should be accessible to people with physical or intellectual disabilities and make use of appropriate mediums, including opportunities available from new media.

Reporting

The Commission should give consideration to the integration of patient experience indicators with outcome and access indicators so that all indicators can be considered jointly within an accountability framework.

Additionally, the format and distribution of reporting should be considered with respect to the level of access by health services and the public. There may be some level of investment required in developing and maintaining reporting tools, such as web-based reports.

Implementation: big bang versus phased approach

The Commission may consider the following implementation options associated with measuring consumer feedback. The recommended approach is to use the survey to measure patient experience across all three tiers, domains and areas of health to establish a robust baseline from which to commence regular measurement and

benchmarking within services. A complete implementation of the survey will also be necessary to realise the potential of the accountability framework.

With a concentration of effort and provision of appropriate resources, this could be achieved by July 2014. This assumes the momentum developed by this project is maintained to the next stage activities.

Although the recommendation is to develop a survey to roll out, a range of options is presented below in Table 7.

Table 7 Potential scope of survey

Scope of survey	Benefits	Risks
1. Full coverage: All tiers, domains and areas of health	<ul style="list-style-type: none"> • Robust baseline from which to compare performance • Measurement of patient experience across all areas of health • Enables full benefit of accountability framework to be realised 	<ul style="list-style-type: none"> • Significant work required if delivery date intended to be by July 2014
2. Limited coverage: Lead survey on one domain, E.g. communication	<ul style="list-style-type: none"> • Timescales for development are likely to be shorter than option 1 	<ul style="list-style-type: none"> • Gaps in accountability framework associated with patient experience in areas outside domain of measurement • Methodological work and cognitive testing may present missed economy of scale opportunity compared to if all domains developed at same time
3. Limited coverage: One area of health, e.g. maternity services	<ul style="list-style-type: none"> • Timescales for development are likely to be shorter than option 1 	<ul style="list-style-type: none"> • Gaps in measuring patient experience in some areas of health • Methodological work and cognitive testing may present missed economy of scale opportunity compared to if all areas of health developed at same time
4. Combination of 2 or 3, e.g. one domain in one area of health	<ul style="list-style-type: none"> • Shortest possible timescales likely to provide some information on patient experience 	<ul style="list-style-type: none"> • As per options 2 and 3, though arguably the effect of these risks are greater since the focus of option 4 is much narrower

Discounted options

Options to survey a limited number of DHBs or only domains are not recommended and have not been presented in the table above. Rolling out the survey to a limited number of DHBs would represent a poor return on investment since the majority of the planning work would occur regardless of the number of DHBs included. Similarly, surveying on national indicators only would require the collection of one aspect without information on indicators to populate the broader overarching indicator. This would be inconsistent with our recommendation on how indicators should be aggregated using lower level indicators across all tiers. It would also mean that the methodological approach would need to be revised if/when full survey coverage was rolled out across indicators and areas of health.

10 Conclusions

This report represents the start of the journey. It is the first critical milestone on a journey towards a consistent and coherent patient experience measurement framework that drives better quality care. By building on experience globally, it also represents an opportunity for New Zealand to create a leading approach that best helps patients while creating minimum burden for those that apply it.

By determining what to measure at the national and DHB level, this project represents the first critical step in a journey. This is the journey to establish, embed and apply a coherent set of national patient indicators across New Zealand's health system that are used to drive improved quality care. Following on from this project, significant work remains to determine how best to measure the domains and indicators identified and how to implement this framework.

This project includes the following findings based on current international best practices, consultation exercises with over 60 people representing DHBs, consumer groups, the Ministry and primary care in two workshops as well as meetings with the Ministry of Health and an e-questionnaire.

Project recommendations and findings:

- Recommendation 1: Measuring patient experience should be based on four domains, each with five indicator drivers reflecting what is important to patient experience across primary and secondary care environments
- Recommendation 2: A patient experience survey should be developed based on individual survey questions asked directly to patients. Qualitative measures including patient stories, focus groups and interviews can also be used to complement the surveys and provide additional detail at a local level
- Recommendation 3: The results of survey questions should be aggregated to measure the five indicator drivers within each domain. The indicator drivers should then be aggregated to develop a single indicator for each domain
- Finding: The aggregation of national indicators at a domain level should be used to drive accountability
- Recommendation 5: DHB indicator drivers and responses to survey questions should be reported and monitored by DHBs/providers
- Recommendation 6: The roll out of a survey should be in full across all areas of health and all domains rather than a piecemeal or phased approach
- Finding: There is a compliance burden and cost associated with a survey that is dependent on the survey methodology selected
- Recommendation 7: Further consultation is recommended to finalise domains and prepare the accountability framework.

Appendix A: NHS Patient Experience Framework³³

- Respect for patient-centred values, preferences, and expressed needs, including: cultural issues; the dignity, privacy and independence of patients and service users; an awareness of quality-of-life issues; and shared decision making
- Coordination and integration of care across the health and social care system
- Information, communication, and education on clinical status, progress, prognosis, and processes of care in order to facilitate autonomy, self-care and health promotion
- Physical comfort including pain management, help with activities of daily living, and clean and comfortable surroundings
- Emotional support and alleviation of fear and anxiety about such issues such as clinical status, prognosis, and the impact of illness on patients, their families and their finances
- Welcoming the involvement of family and friends, on whom patients and service users rely, in decision-making and demonstrating awareness and accommodation of their needs as care-givers
- Transition and continuity regarding information that will help patients care for themselves away from a clinical setting, and coordination, planning, and support to ease transitions
- Access to care with attention for example, to time spent waiting for admission or time between admission and placement in a room in an in-patient setting, and waiting time for an appointment or visit in the out-patient, primary care or social care setting.

³³ NHS Patient Experience Framework (2011). Available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/146831/dh_132788.pdf Accessed on 24 May 2013.

Appendix B: International measurement methodologies used to measure patient experience indicators

Table 8: NHS patient experience framework and the American CAHPS

Measurement methodologies	NHS patient experience framework	American CAHPS
Domains	<p>NHS patient experience framework:</p> <ol style="list-style-type: none"> 1. Respect of patient-centred values, preferences, and expressed needs, including: cultural issues; the dignity, privacy and independence of patients and service users; an awareness of quality-of-life issues; and shared decision making 2. Coordination and integration of care across health and the social care system 3. Information, communication, and education on clinical status, progress, prognosis, and processes of care in order to facilitate autonomy, self-care and health promotion 4. Physical comfort including pain management, help with activities of daily living, and clean and comfortable surroundings 5. Emotional support and alleviation of fear and anxiety about such issues as clinical status, prognosis, and the impact of illness on patients, their families and their finances 6. Welcoming the involvement of family and friends, on whom patients and service users rely, in decision-making and demonstrating awareness and accommodation of their needs as care-givers 	<ul style="list-style-type: none"> Communication with doctors Communication with nurses Responsiveness of hospital staff Communication about medicines Pain control Cleanliness and quietness of physical environment Discharge information

Measurement methodologies	NHS patient experience framework	American CAHPS
	<p>7. Transition and continuity regarding information that will help patients care for themselves away from a clinical setting, and coordination, planning, and support to ease transition</p> <p>8. Access to care with attention for example, to time spent waiting for admission or time between admission and placement in a room in an in-patient setting, and waiting time for an appointment or visit in the out-patient, primary care or social care setting.</p>	

Table 9: Picker Principles of Patient-Centred Care

Picker Principle	Description
Respect for patients' values, preferences and expressed needs	<p>Patients want to be kept informed regarding their medical condition and involved in decision-making. Patients indicate that they want hospital staff to recognise and treat them in an atmosphere that is focused on the patient as an individual presenting with a medical condition.</p> <p>Illness and medical treatment may have an impact on quality of life. Care should be provided in an atmosphere that is respectful of the individual patient and focused on quality-of-life issues.</p> <p>Informed and shared decision-making is a central component of patient-centered care.</p> <p>Provide the patient with dignity, respect and sensitivity to his/her cultural values.</p>
Coordination and integration of care	<p>Patients, in focus groups, expressed feeling vulnerable and powerless in the face of illness. Proper coordination of care can ease those feelings. Patients identified three areas in which care coordination can reduce feelings of vulnerability:</p> <ul style="list-style-type: none"> - Coordination and integration of clinical care - Coordination and integration of ancillary and support services - Coordination and integration of front-line patient care

Picker Principle	Description
Information, communication and education	<p>Patients often express the fear that information is being withheld from them and that they are not being completely informed about their condition or prognosis. Based on patient interviews, hospitals can focus on three kinds of communication to reduce these fears</p> <ul style="list-style-type: none"> - Information on clinical status, progress and prognosis - Information on processes of care - Information and education to facilitate autonomy, self-care and health promotion
Physical comfort	<p>The level of physical comfort patients report has a tremendous impact on their experience. From the patient's perspective, physical care that comforts patients, especially when they are acutely ill, is one of the most elemental services that caregivers can provide. Three areas were reported as particularly important to patients:</p> <ul style="list-style-type: none"> - Pain management - Assistance with activities and daily living needs - Hospital surroundings and environment kept in focus, including ensuring that the patient's needs for privacy are accommodated and that patient areas are kept clean and comfortable, with appropriate accessibility for visits by family and friends.
Emotional support and alleviation of fear and anxiety	<p>Fear and anxiety associated with illness can be as debilitating as the physical effects. Caregivers should pay particular attention to:</p> <ul style="list-style-type: none"> - Anxiety over clinical status, treatment and prognosis - Anxiety over the impact of the illness on themselves and family - Anxiety over the financial impact of illness.
Involvement of family and friends	<p>Patients continually addressed the role of family and friends in the patient experience, often expressing concern about the impact illness has on family and friends. These principles of patient-centered care were identified as follows:</p> <ul style="list-style-type: none"> - Accommodation, by clinicians and caregivers, of family and friends on whom the patient relies for social and emotional support - Respect for and recognition of the patient "advocate's" role in decision-making - Support for family members as caregivers - Recognition of the needs of family and friends

Picker Principle	Description
Transition and continuity	<p>Patients often expressed considerable anxiety about their ability to care for themselves after discharge. Meeting patient needs in this area requires staff to:</p> <ul style="list-style-type: none"> - Provide understandable, detailed information regarding medications, physical limitations, dietary needs, etc - Coordinate and plan ongoing treatment and services after discharge and ensure that patients and family understand this information - Provide information regarding access to clinical, social, physical and financial support on a continuing basis.
Access to care	<p>Patients need to know they can access care when it is needed. Attention must also be given to time spent waiting for admission or time between admission and allocation to a bed in a ward. Focusing mainly on ambulatory care, the following areas were of importance to the patient:</p> <ul style="list-style-type: none"> - Access to the location of hospitals, clinics and physician offices - Availability of transportation - Ease of scheduling appointments - Availability of appointments when needed - Accessibility to specialists or specialty services when a referral is made - Clear instructions provided regarding when and how to obtain referrals.

Table 10: What matters to patients across acute and primary care: selected research

International studies showing consistency with Picker Patient Care domains: Findings from the literature based on what matters to patients across acute and primary care	
<p>Doctors know enough about my medical history and treatment</p> <p>Doctors can answer questions about my condition and treatment in a way that I can understand</p> <p>I have confidence and trust in the hospital staff who treat me</p> <p>Doctors wash or clean their hands between touching patients</p> <p>Nurses know enough about my medical history and treatment</p> <p>Before my operation or procedure, I get a clear explanation of what will happen</p> <p>Risks and benefits of my operation or procedure are explained to me in a way that I can understand</p> <p>Nurses wash or clean their hands between touching patients</p> <p>Rooms and ward are clean</p> <p>Doctors and nurses are open with me about my treatment or condition</p> <p>Boyd (2007), UK</p> <p>Access to systems and staff</p> <p>Environment and facilities</p> <p>Good communication and information</p> <p>Expert clinical care</p> <p>Continuity and coordination</p> <p>Bruster (2008), UK</p> <p>Information about care, including running of hospital, foods that could be eaten and side effects of medications</p> <p>Insufficient time spent with patients by physicians discussing what to do at home, and insufficient time nurses spent with patients</p> <p>Cleary et al, (1991), US</p> <p>Access and waiting</p> <p>Better information about health and healthcare</p> <p>Environmental needs in health care settings</p> <p>Building relationships and trusting professionals</p> <p>Emotional impact of accessing health care</p> <p>Involvement in decisions and control over choices</p>	<p>Fast access to reliable health advice</p> <p>Effective treatment by trusted professionals</p> <p>Participation in decisions and respect for preferences</p> <p>Clear, comprehensible information and support for self care</p> <p>Attention to physical and environmental needs</p> <p>Emotional support, empathy, and respect</p> <p>Involvement of, and support for, family and carers</p> <p>Continuity of care and smooth transitions</p> <p>Coulter, (2005), UK</p> <p>Education and shared knowledge</p> <p>Involvement of family and friends</p> <p>Collaboration and team management</p> <p>Sensitivity to non-medical and spiritual dimensions</p> <p>Respect for patient needs and preferences</p> <p>Free flow and accessibility of information</p> <p>Cronin (2004), US</p> <p>Respect for patients' preferences and values</p> <p>Emotional support</p> <p>Physical comfort</p> <p>Information, communication and education</p> <p>Continuity and transition</p> <p>Coordination of care</p> <p>The involvement of family and friends</p> <p>- access to care</p> <p>Gerteis et al (2003), US</p> <p>Consistency and coordination of care</p> <p>Treatment with respect and dignity</p> <p>Involvement in decisions</p> <p>Doctors</p> <p>Nurses</p> <p>Cleanliness</p> <p>Pain control</p> <p>Sizmur & Redding (2009), UK</p>

International studies showing consistency with Picker Patient Care domains: Findings from the literature based on what matters to patients across acute and primary care

**Coates-Duton & Cunningham-Burley
(2009), UK**

Appendix C: Examples from NHS Choices relating to patient experience domains

Table 11: NHS Choices feedback relating to patient experience domains

Communication domain ^{34 35}
<p>"My doctor even remembers things that I have said during previous appointments, that haven't been written in my records – how's that for personalised, individual treatment?!" Patient Comment – NHS Choices</p> <p>"They hear and listen and take on board your concerns, and then discuss those concerns with you and send you on your way" Patient Comment – NHS Choices</p> <p>"I am sorry but this is my worst doctor's experience ever. I am sick, have a chesty cough and coughing up blood. I was in and out of the doctor's surgery in less than a minute and told to take paracetamol. I haven't visited for over 3 years and was obviously concerned about my health to go this time. I am still feeling very ill and need to consider my options. Do I need to pay to have my health taken seriously? Might as well close this surgery down. Waste of money!" Patient Comment – NHS Choices</p> <p>"The care is great, and the service is outstanding. But sometimes I don't know what I should have asked. I go home and don't feel like I really know what's going on." Patient Comment – Planetree</p> <p>"On the unit in particular, I don't remember being called by my name in the six days I was there. They asked me what name I would like to be called and I told them but they didn't use it." Patient Comment – Planetree</p> <p>"I felt like I was interrupting them when I asked for help." Patient Comment – Planetree</p>
Partnership domain ³⁶
<p>"What matters to me is being listened to, believed, taken seriously and feeling like what I say matters and having a say in what happens to me" Crisis service user, Mental Health Foundation</p> <p>"If my family had any suggestions to make it would be that there should be more, readily available advice and information for family and carers early on in the recover process." – Strokes in Adulthood, Different Strokes</p>

³⁴ NHS Institute for Innovation and Improvement (2012) NQB Patient Experience Framework with referenced patient quotes Available at <http://www.institute.nhs.uk/images/documents/Share%20and%20network/PEN/NQB%20Framework%20with%20Patient%20Quotes.pdf>. Accessed on 31 May 2013.

³⁵ Planetree and Picker Institute (2008) Practical approaches for building a patient-centred culture. Available <http://www.patient-centeredcare.org/chapters/chapter7a.pdf>. Accessed on 31 May 2013.

³⁶ NHS Institute for Innovation and Improvement (2012) NQB Patient Experience Framework with referenced patient quotes Available at <http://www.institute.nhs.uk/images/documents/Share%20and%20network/PEN/NQB%20Framework%20with%20Patient%20Quotes.pdf>. Accessed on 31 May 2013.

Coordination domain^{37 38}

“Sometimes just having someone familiar on the end of the phone who you can ask a simple question to and get a straightforward answer is all you need” Patient with a heart condition cited in the Kings Fund

“Also I have been assigned a doctor who on making an appointment for them have only been able to see twice in nearly twelve months, although able to see other doctors, this can't be good practice when you want to build confidence in YOUR GP.” Patient Comment – NHS Choices

Physical and Emotional needs domain³⁹

“First and foremost, the doctors strike me as being quite exceptional; they are clued-up and wise, willing to give time even when running late and emphatically on the side of the patient. One of the GPs came to visit me in hospital when I was in hospital earlier this year, which was enormously welcome but no surprise considering the dedicated style of the doctor concerned.” Patient Comment – NHS Choices

“It saved my life. I mean if I'd had to go on in the pain I was in...I have a friend and both his hips started to go and he said, 'If I can't do anything about it I'm going to kill myself because I just can't stand it' People who have arthritis know how painful it is...if you have it in your figures first just imagine that in your hip...it's life affirming.” Patient Interview, What Matters to Patients

“The provision of emotional and psychological support should be an integral part of a diabetes service. Emotional and psychological needs of a person with diabetes have to be properly assessed in partnership with the person as part of the care planning process. It is important that people are made aware of the support available, so that they are able to choose if and when they need to access it.” Improving supported self-management for people with diabetes. Diabetes UK.

³⁷ NHS Institute for Innovation and Improvement (2012) NQB Patient Experience Framework with referenced patient quotes Available at

<http://www.institute.nhs.uk/images/documents/Share%20and%20network/PEN/NQB%20Framework%20with%20Patient%20Quotes.pdf>. Accessed on 31 May 2013.

³⁸ Kings Fund (2012) From vision to action Making patient-centred care a reality. Available at

http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/Richmond-group-from-vision-to-action-april-2012-1.pdf. Accessed on 31 May 2013.

³⁹ NHS Institute for Innovation and Improvement (2012) NQB Patient Experience Framework with referenced patient quotes Available at

<http://www.institute.nhs.uk/images/documents/Share%20and%20network/PEN/NQB%20Framework%20with%20Patient%20Quotes.pdf>. Accessed on 31 May 2013.

Appendix D: Strengths and limitations of feedback methods

A list of some key strengths and limitations of the quantitative methods and qualitative approaches of administering the different options are outlined in below in Table 12. This table has been reproduced from the Kings Fund.

Table 12: Strengths and limitations of feedback methods

Feedback method	Strengths	Limitations
Quantitative		
Postal survey (self-completion)	<ul style="list-style-type: none"> Can reach large numbers Less intrusive than other methods No interviewer bias Questionnaires can be fairly long and detailed Can collect demographic data Possible to achieve high response rates if reminders are sent Relatively cheap 	<ul style="list-style-type: none"> Not suitable for those with very low literacy Not suitable for non-English speakers unless language known in advance or translation service available Requires careful administration Data entry (manual or scanned) takes time Requires expertise in use of statistical package for analysis
Face-to-face survey	<ul style="list-style-type: none"> Suitable for low literacy groups Can include more detailed/complex questions Can collect demographic data Can enter data during interview (CAPI)* 	<ul style="list-style-type: none"> Training required for interviewers Similar problems as for postal surveys re other languages, data entry (without CAPI)* and analysis Time-consuming and expensive
Telephone survey	<ul style="list-style-type: none"> Suitable for low literacy groups Can enter data while conducting interview (CATI)† Results can be available quickly 	<ul style="list-style-type: none"> Requires list of phone numbers Response rates often low Requires frequent call-backs at different times of day to get representative sample Questionnaire needs to be brief Interviewers must be trained
Automated telephone survey (IVR)	<ul style="list-style-type: none"> Suitable for low literacy groups Data entered automatically Can be produced in multiple languages 	<ul style="list-style-type: none"> Requires list of phone numbers Acceptability can be low, leading to low response rates Questionnaire needs to be very brief
Online survey (email or web-based)	<ul style="list-style-type: none"> User-friendly design – questions can be tailored to respondent and ‘skips’ avoided leading to better item-response completeness 	<ul style="list-style-type: none"> Requires list of email addresses or invitation to go to a website Not suitable for people who do not have internet access, so representative coverage usually impossible Questionnaire needs to be brief

Feedback method	Strengths	Limitations
	Reminders are easy to send Data entry is automatic allowing for rapid turnaround of results	Must take account of differences in computer systems and browsers
Survey using hand-held portable devices	Used for on-site data collection Questionnaires easily tailored to local setting Automatic data entry Rapid turnaround of results possible	Questionnaires must be brief Attention must be paid to infection control if patients are to handle devices Someone must take responsibility for the PDA devices and monitoring use May be difficult to calculate response rates
Survey using touch-screen kiosks	Used for on-site data collection Can be sited in waiting rooms or clinics Automatic data entry Rapid turnaround of results possible	Questionnaires must be brief Attention must be paid to infection control if patients are to handle devices Impossible to calculate response rates because denominator is unknown Hard to prevent multiple responses or staff masquerading as patients
Survey using bedside media consoles	Can be completed by patients while in bed Reminders and incentives (e.g., reduced cost phone calls) are possible Automatic data entry Rapid turnaround of results	Some patients don't want to use bedside consoles because they are expensive No control over timing of survey Difficult to calculate response rates
Routine statistics	Using routine or administrative data can be cost-effective Utilisation patterns may be indicative of underlying problems	An indirect measure of patients' experiences
Qualitative		
In-depth interviews	Can produce richer, more detailed data Allows respondents to express themselves in their own words	Expensive Interviewers must be trained Problem of interviewer bias Transcribing and data analysis is time-consuming
Discovery interviews	Means of recording patient stories, which may increase staff understanding	Interviewers must be trained Problem of interviewer bias Patients may be unwilling to be critical when interviewed by staff Transcribing and data analysis is time-consuming
Focus groups	Rich source of data on experiences and their impact on patients Groups often 'spark' off	Moderators need training Responses can be influenced by dominant individuals Transcribing and data analysis is time-

Feedback method	Strengths	Limitations
	each other to produce less predictable responses	consuming
Web-based comments (free text)	<p>Allows people to make any comments they want to about the care they've received</p> <p>Respondents can be asked to give their views on specific topics</p> <p>Responses are available for others to read</p>	<p>Not suitable for people who do not have internet access</p> <p>Sites must be moderated to avoid malicious comments</p>
Comment cards, exit surveys, suggestion boxes, video boxes (on-site)	<p>Can be used to collect on-site feedback, usually unstructured</p> <p>Feedback can be analysed quickly</p>	Likely to be completed by a small minority unless specifically invited to respond
Complaints and compliments	All trusts receive some of these so they can be analysed for identifying specific incidents and general trends	<p>Most people don't make formal complaints even when things go wrong</p> <p>Compliments are often made but not often in writing</p>
Patient diaries	<p>Can be used to gather continuous feedback on patient journey</p> <p>Allows for unstructured feedback</p>	<p>Places a considerable burden on patients to record relevant information</p> <p>Can produce voluminous data that is difficult to analyse</p> <p>Not suitable for those with low literacy</p>
Mystery shopping and observation	<p>A useful way of testing services from patient's perspective if service users are involved</p> <p>Staff can observe patient's journey through the system</p>	<p>Involves an element of deception – must comply with ethical guidelines</p> <p>Some aspects of experience are impossible to replicate</p> <p>If staff are observing their presence this may influence what happens</p>
Customer journey mapping	A mixed methods approach that involves staff and patients in mapping care pathways	Requires careful co-ordination and training Time-consuming and resource-intensive

Source: *The Kings Fund*

Appendix E: Stakeholder consultation

Two workshops were held on the 13th of June 2013 with representatives from across the health sector, including clinical, DHB management and consumer representatives. The workshops had three main aims:

- 1 To introduce attendees to this project's objectives, success criteria and team.
- 2 To seek feedback on the measurement domains and indicators proposed by KPMG
- 3 To seek views on what is important for New Zealand - to tailor the indicators.

Approximately 61 people attended these workshops. The attendees, their role and the group or organisation they represented (where available) are recorded below.

Table 13 Stakeholder attending workshops

Name	Role	Group / organisation
Sarah Devine	Quality Projects	Auckland DHB
Tony O'Connor	Engagement and Planning Manager	Auckland DHB
Helen Mason	General Manager Planning and Funding	Bay of Plenty DHB
Emma Taylor (Kenagy)	Project Facilitator, Corporate Quality & Patient Safety	Canterbury District Health Board
Kate MacIntyre	Patient Safety Officer	Capital & Coast DHB
Gail Thomson	Quality & Risk Manager	Capital & Coast DHB
Linda Baxter	Project Manager	Capital & Coast DHB
Caroline Fuge	Quality Manager - Surgical Womens and Childrens Directorate	Capital & Coast DHB
Julian N. Paton	Consumer Advisor	Central Cancer Network
Stephanie Fletcher	Project Manager	Central Cancer Network
Jane Cullen		Central PHO
Sheridan Pooley	Regional Consumer Advisor	Community Alcohol & Drugs Services - Waitemata DHB
Solitaire Henare	Community Liasion Manager	Counties Manukau DHB
Salin Reji	Consumer Experience Coordinator	Counties Manukau Health
Jo Fitzpatrick	Board member	Diabetes New Zealand
Lynne Lane	Mental Health Commissioner	Health & Disability Commission
Cynthia Maling	Contractor	Health & Disability Commission
Gillian Bohm	Principal Advisor Quality Improvement	Health Quality & Safety Commission
Richard Hamblin	Director of Quality Evaluation	Health Quality & Safety Commission
Isobel Williams	Board Secretary	Health Quality & Safety Commission
Chris Walsh	Senior Advisor - Consumer Engagement	Health Quality & Safety Commission

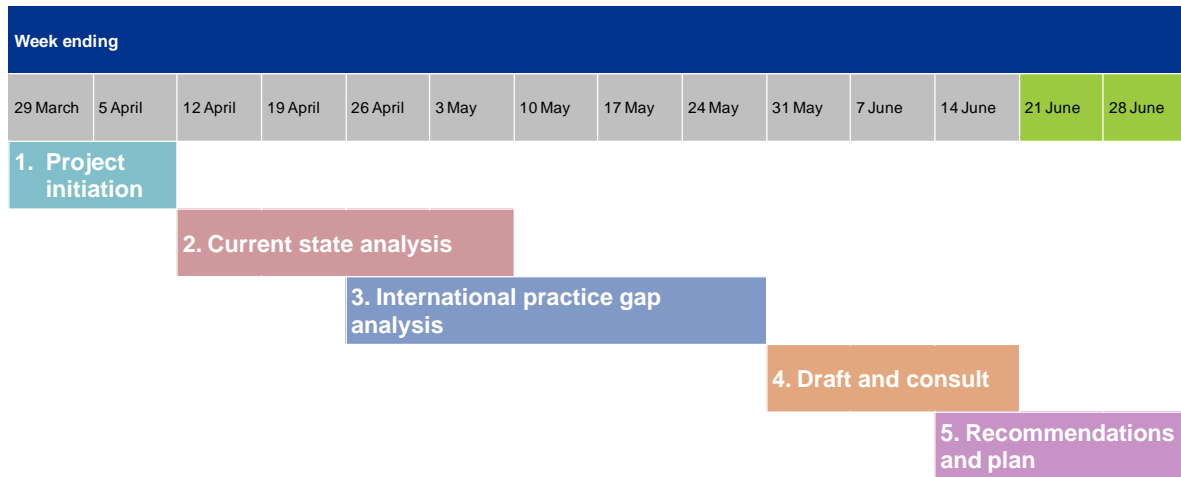
Anne Curtis	Coordinator	HealthLink North
Abby O'Neill	Quality Advisor	Hutt Valley DHB
Helen Honstvet	National Self Advocacy Manager	IHC
Claire Stewart	Advocate	IHC
Peter Barnett	Board Member	Kites Trust
Vivienne Ayres	Manager — DHB Planning & Accountability	MidCentral DHB
Vivienne Ayres	Manager — DHB Planning & Accountability	MidCentral DHB
Quentin Bourke	Performance and Planning Unit,	MidCentral DHB
Muriel Hancock	Director - Patient Safety and Clinical Effectiveness	MidCentral DHB
Rebecca Drew	Consultant - Primary Care	Ministry of Health
Alison Randall	Principal Advisor - System Integration	Ministry of Health
Peter Himona	Senior Analyst	Ministry of Health
Anne O'Brien	Senior Policy Analyst	Ministry of Health
Lynette Drew	Senior Advisor - Post Acute Demand	Ministry of Health
Liz Stirling	Principal Technical Specialist Performance	Ministry of Health
Patricia Cunniffe	Consumer Panel Member	New Zealand Health Information Service
Deborah Dalliessi	Coordinator	North Shore Community Health Voice
Sarah Bell	Project Manager	Northern Cancer Network
Christine McKerrow	Quality Assurance Manager	Northland DHB
Karen Ludgate	Admin Support - Surveys	Northland DHB
Lisa Skeet	Director	Safe Staffing and Healthy Workplaces
Chris Eccleston	General Manager Clinical Governance	South Canterbury DHB
Jenny Ryan	Nurse Coordinator - Quality And Risk	South Canterbury DHB
Tina Gilbertson	Director of Quality	Southern DHB
Mark Bowen	Team Leader - Quality & Risk	Southern DHB
Amelia Brown-Smith	Quality and Risk Management Team Leader	Southern DHB
Jeanette McKeogh	Group Manager - Strategy & Standards	The Royal New Zealand College of General Practitioners
Dr Jane Burrell	General Practitioner	The Royal New Zealand College of General Practitioners
Faye Seumanatafa	DIAS Coordinator	Vaka Tautua / Le Va
Mo Neville	Assistant Group Manager - Quality and Patient Safety	Waikato DHB
Wendy Entwistle	Facilitator - Consumer Engagement	Waikato DHB

Gillian Malton	Quality Coordinator	Wairarapa District Health Board
Tracy McIntyre	Coordinator	Waitakere Health Link
Katrina.Lenzie-Smith	Programme Manager	Waitemata DHB
Stacey Hurrell	Quality Assurance Manager	Waitemata DHB
Imelda Quilly-King	Community Engagement	Waitemata DHB
Robyn Moore	Consumer Representative	West Coast District Health Board's Clinical Board
Julie Radford-Poupard	Director	Women's Health Action
Dr Sandy Hall	Policy Analyst	Women's Health Action
Barbara Holland	Consumer Representative	Independent

Appendix F: Summary of approach

The key steps undertaken between 29 March and 28 June 2013 to deliver the project objectives are shown below.

Figure 9: KPMG Project timeline



1. Project initiation. Key activities included:

- Project kick-off meeting
- Developing Project Plan
- Issuing communication brief to stakeholders
- Agreement of risks, issues, success criteria

Deliverable: Agreement on and scheduling stakeholder engagement process and Project Plan

2. Current state analysis. Key activities included:

- Engaging DHBs to identify current processes for capturing patient/ consumer experience
- Garnering information from all DHBs on systems for capturing patient/consumer experience
- Collating results and associated documentation provided from each DHB into a report
- Undertaking analysis of information provided

Deliverable: Presented primary analysis to Commission

3. International practice gap analysis. Key activities included:

Identifying best practice in patient/consumer experience in relation to measuring patient experience. The results of this exercise are presented as an appendix to this report
Undertaking gap analysis of results against international best practice
Validating gap analysis with international experts.

Deliverable: Presented gap analysis to Commission

4. Draft and consult. Key activities included:

Incorporating leading practice, expert and global insights into development of indicators
Drafting indicators for patient/consumer experience
Identifying measures for data collection, including data definitions
Conducting facilitated workshops with key stakeholders to review draft indicators

Deliverable: Presented data definitions and draft indicators to Commission

5. Recommendations and plan. Key activities included:

Finalising indicators following consultation feedback
Recommendations for new improved methods of capturing, analysing and reporting consumer experience proposed.

Deliverable: Final report to Commission

Appendix G: Literature scan

This Appendix provides a summary of the international literature scan on measuring consumer experience. The summary outlines:

- what is important to consumers and how this can be translated into developing indicators
- the benefits of measuring consumer experience
- the role of governance and performance management frameworks in creating accountability structures to support improvement activities

The summary of evidence and best practices are principally sourced from Australia, the United Kingdom (UK), The United States of America (US) and the Netherlands

The international literature scan is presented as a supplement to this report.

Scope of the literature scan

The scope of the literature scan included a high level review of international best practices from academic and grey literature sources. It did not constitute a full literature review. The focus included literature from Australia, the UK, the US and the Netherlands. These jurisdictions were examined with respect to:

- **a consensus of why patient experience should be measured** - benefits of measuring patient experience and potential consequences of not doing so. This included the findings of the Inquiry into the Mid Staffordshire National Health Service (NHS) Foundation Trust (FT)
- **common indicators used to measure patient experience** - including a description of what is being measured internationally
- **measurement considerations** – including an outline of methods to measure consumer experience
- **critical success factors in improving consumer experience** – including the role of governance and performance management frameworks
- **jurisdictional summaries of measurement approaches** – including how consumer experience is measured in Australia, the UK, the US and the Netherlands.

Key findings from the literature scan

Why measure patient experience

- A patient centred approach to healthcare involves understanding and acting on what matters to patients. Benefits of listening to patients and acting on feedback can support a wide range of improvements to the quality of care provided to patients and their experiences of and interactions with health care providers. Conversely not listening to patients or acting on feedback has been linked to failing hospitals and drawn out as contributing to poor patient care in such high profile investigations such as the Mid Staffordshire NHS Foundation Trust Inquiry in England and the Garling Report Special Commission of Inquiry into Acute Care Services in New South Wales Public Hospitals.

Measuring what matters to patients

- Effective measurement of patient experience requires identifying what is important to patients, incorporating this in a framework and developing appropriate approaches to measure these areas. A strong measurement framework is a feature of well developed approaches in Australia, the US, the UK and the Netherlands.
- The Picker organisation lists eight Principles of Patient-Centred Care and these are grounded in measurement approaches in the UK and some Australian surveys. These principles also influenced the development of other leading methodologies, including the American CAHPS and Dutch CQ-index. Picker principles include:
 1. Respect for patients' values, preferences and expressed needs
 2. Coordination and integration of care
 3. Information, communication and education
 4. Physical comfort
 5. Emotional support and alleviation of fear and anxiety
 6. Involvement of family and friends
 7. Transition and continuity
 8. Access to care.

From patient satisfaction to patient experience

- There has been a movement away from measures of patient satisfaction such as broad questions like "*how would you rate your care in hospital*" to approaches which measure patient experience. Experience questions might ask, for example, patients to report their experiences of a particular service, clinician or specific part of their interaction with health care services. Patient *experience* questions therefore, seek to elicit information on what actually occurred to the patient, as opposed to the patient's evaluation of what occurred. Patient experience questions offer benefits over satisfaction based questions by avoiding potentially artificially high positive responses by using factual questions about events and occurrences, reducing the subjectivity and other potentials for bias from differences in expectations or response tendencies and provide a much easier way to interpret and respond to patient feedback.

Aligning indicators with a measurement framework

- The relationship between indicators within a framework should be clear from the national level to individual health services. For example: health service or unit level

indicators may be more detailed than national level indicators and more specific to areas requiring attention or flexibility with respect to timing.

- When developing a framework to measure patient experience, the framework should be clear about the measurement approach; where and when to measure patient experience, including at point of contact, post treatment and/or continuously; and also consider data issues such as the source of information, data quality, completeness, continuity, numerator and denominator and aggregation.

Accountability arrangements for measuring patient experience

- Measures must form part of a coherent performance management framework. Features of a well functioning performance management framework incorporating patient experience should include formalised and regular monitoring and reporting in the organisation, clear responsibilities for using patient experience information and triggers to act on exceptions.

What matters to patients and why does it matter?

In this section the potential benefits of listening and acting on patient feedback is discussed in terms of the effect on high quality care and patients' experiences of and interactions with health care providers. The potential consequences of failing to listen or act on patient feedback is also discussed with reference to examples from two high profile reviews where patient experience was cited as a contributory factor to poor outcomes for patients.

What matters to patients?

There has been a significant amount of research conducted on what is important to patients and how this can be translated into domains from which feedback can be measured.

Patient experience indicators must be grounded in what is important to patients, rather than the priorities of clinicians, planners and administrators. The approach or framework must be patient centric to deliver measureable improvements that are of value to the patient and their families. In developing the framework for NZ, the approach of the three recognised, international leaders of patient-centred methods of measuring the patient experience should be considered. These are; the Picker Institute, the American Consumer Assessment of Healthcare Providers and Systems (CAHPS) and the Dutch Consumer Quality Index (CQ-index). It must be noted that the later two are influenced by the work of the Picker Institute.

The Picker Institute has developed and refined the principles of patient centred care and the patient experience since the mid 1990's. The Picker Institute Principles of Patient-Centred Care (Picker Principles) are widely used for developing measures of the patient experience and with the CAHPS and CQ-index informed by the Picker Principles to some degree. The American CAHPS was developed by Harvard University based on the Picker Principles, the Dutch CQ-index is based on the CAHPS and the Quality of care through the patient's eyes (QUOTE) instruments. With some minor adaptation, the Picker Principles have been used successfully as the basis for measurement of patient experience in the UK, US, the Netherlands and Australia.

In the United Kingdom, the National Health Service (NHS) patient survey and patient experience framework are also based on modified versions of the Picker Principles. Modifications include the addition of elements on ensuring dignity, privacy and independence of service users, supporting decision making and supporting self-management. The coverage of Picker Principles in domains for patient experience also extends to Australia, where several state and territory based surveys reference the Picker Principles.

Alongside the Picker Principles, the Institute of Medicine's (IoM) six domains of patient centred care also represent a generic framework which measure 'what matters most' to patients. The two approaches are based on broadly the same primary research: 1) IoM 2001 'Crossing the Quality Chasm' report; and, 2) Picker/Harvard 'Through the Patients Eyes' (Gerteis et al, 2003)⁴⁰. However, the Picker Principles include the additional domains of "transition and continuity", and "access to care". A comparison of the two frameworks and their domains can be seen below in Table 14.

⁴⁰ The Kings Fund (2011) What matters to patients? Developing the evidence base for measuring and improving patient experience. Available at

http://www.institute.nhs.uk/images/Patient_Experience/Final%20Project%20Report%20pdf%20doc%20january%202012.pdf. Accessed on 29 May 2013

Table 14 Frameworks measuring what matters most to patients: Picker Principles and IOM domains of patient-centred care

Picker Principles of Patient centred care	The Institute of Medicine's domains of patient-centred care:
1. Respect for patients' values, preferences and expressed needs	1. Responsiveness to needs, values and expressed preferences
2. Coordination and integration of care	2. Coordination and integration
3. Information, communication and education	3. Information, communication and education
4. Physical comfort	4. Physical comfort
5. Emotional support and alleviation of fear and anxiety	5. Emotional support, relieving fear and anxiety
6. Involvement of family and friends	6. Involvement of family and friends.
7. Transition and continuity	
8. Access to care.	

The evidence base for the Picker Principles is founded on a multi-year research project, which was aimed at the development of scientifically validated patient-experience surveys. The research was conducted by the Picker/Commonwealth Program for Patient-Centred Care. The method included a national survey in the United States of over 6,000 hospital patients and 2,000 care partners from sixty-two hospitals; and focus groups with patients and their family members.⁴¹ The information garnered defined the patient's perspective and led to the foundation of Picker surveys for the measurement of patient experience.⁴² More recent studies confirm the robustness of the Picker Principles. Key articles by Boyd (2007), Bruster (2008), Cleary et al, (1991), Coates-Duton & Cunningham-Burley (2009), Coulter (2005), Cronin (2004), Gerteis et al (2003) and Sizmur & Reading (2009) are consistent with and further validate the seminal work that underpins the Picker Principles.

Why does patient experience matter?

The importance of a patient centred approach to healthcare involves understanding and acting on what matters to patients. Where this is done well there are clear links to improvements in patient experience, health outcomes and other organisational benefits. Where ignored there are, unfortunately, examples of serious failures to patients.

⁴¹ Gerteis et al (2003) 'Through the Patient's Eyes: Understanding and Promoting Patient-Centred Care'

⁴² The Kings Fund (2011) What matters to patients? Developing the evidence base for measuring and improving patient experience. Available at

http://www.institute.nhs.uk/images/Patient_Experience/Final%20Project%20Report%20pdf%20doc%20january%202012.pdf. Accessed on 29 May 2013

Risks of not listening to patients

The failure to listen and respond to patients' and relatives' complaints has been identified as a key factor in failing hospitals⁴³, including most recently at the Mid Staffordshire NHS Foundation Trust (FT). In the Press Statement issued on the release of the final report of the Public Inquiry into Mid Staffordshire NHS FT by Robert Francis QC, the following core reasons for the failure to patients were quoted:

"The Trust Board was weak. It did not listen sufficiently to its patients and staff or ensure the correction of deficiencies brought to the Trust's attention."⁴⁴

"The patient voice was not heard or listened to, either by the Trust Board or local organisations which were meant to represent their interests. Complaints were made but often nothing effective was done about them".⁴⁵

The failure to patients in the case of Mid Staffordshire NHS FT included, in the words of Robert Francis QC, ***"appalling and unnecessary suffering of hundreds of people."*** The extent of the failings and consequences of not listening to patients in the case of Mid Staffordshire NHS FT are illustrated by a further extract from Robert Francis's press statement:

"There was a lack of care, compassion, humanity and leadership. The most basic standards of care were not observed, and fundamental rights to dignity were not respected. Elderly and vulnerable patients were left unwashed, unfed and without fluids. They were deprived of dignity and respect. Some patients had to relieve themselves in their beds when they offered no help to get to the bathroom. Some were left in excrement stained sheets and beds. They had to endure filthy conditions in their wards. There were incidents of callous treatment by ward staff. Patients who could not eat or drink without help did not receive it. Medicines were prescribed but not given. The accident and emergency department as well as some wards had insufficient staff to deliver safe and effective care. Patients were discharged without proper regard for their welfare."⁴⁶

In Australia, following concern over the New South Wales (NSW) hospital system due to some high profile quality and safety incidents, a special Commission of inquiry into NSW health was commissioned. This Inquiry sought to investigate the quality of care provided to patients and their families and friends. The observations and findings of the Garling Inquiry identified similar need to focus on the patient to the Mid Staffordshire Inquiry. This included the observation from a senior health bureaucrat who contributed to the Inquiry that ***"Health needs to move from a craft based industry of many individual professionals practising independently to a managed business where the main goal is excellent patient care provided by multidisciplinary teams and assessed by patient outcomes and patient experience ... including standard models of care for common patient groups with key performance standard defined in performance agreements and implemented through***

⁴³ Coulter, A., Fitzpatrick, R and Cornwell, J. (2009). 'The Point of Care Measures of patients' experience in hospital: purpose, methods and uses'. The King's Fund. Available at <http://www.kingsfund.org.uk/sites/files/kf/Point-of-Care-Measures-of-patients-experience-in-hospital-Kings-Fund-July-2009.pdf>. Accessed on 26 April 2013

⁴⁴ Francis, R (2013). The Mid Staffordshire NHS Foundation Trust Public Inquiry. Press Statement. Available at <http://www.midstaffpublicinquiry.com/sites/default/files/report/Chairman%27s%20statement.pdf>. Accessed on 26 April 2013

⁴⁵ ibid

⁴⁶ ibid

a rigorous process of regular performance review with appropriate rewards and penalties.⁴⁷

Although a health system does not function on the basis of feedback from patients alone, the importance of listening to patients and having a framework with which to respond is clearly imperative to the provision of high quality and patient centred care. The findings from the Mid Staffordshire NHS FT Inquiry reflected this but also included a variety of broader recommendations with respect to high quality standards, measures of compliance, openness and transparency, support for nursing, patient centred healthcare leadership and accurate, useful and relevant information.⁴⁸ Additionally, the Garling Report recommended developing and publishing patient care measurement to clarify whether patients are treated safely and properly.⁴⁹

This involved identifying, developing and publishing patient care measurements to assess how well patients are being looked after, including whether they were treated safely and properly. Within this broad framework collecting patient experience and satisfaction were referenced alongside other indicators, such as access, clinical performance, safety and quality, cost, staff experience and satisfaction and sustainability domains.

Benefits of listening to patients

There are also benefits associated with measuring patient experience. Benefits may include decreases in hospital waiting times, improved medication safety and benefits to admission and discharge processes, infrastructure planning and patient awareness of their rights and complaints management.⁵⁰ Patient feedback has also been cited as being useful to a variety of activities to improve care quality and patient experience. Some of these activities cited by the King's Fund from the United Kingdom (UK) include:⁵¹

- understanding current problems in care delivery
- informing continuous improvement and redesign of services
- helping professionals reflect on their own and their team's practice
- monitoring the impact of any changes
- facilitating benchmarking between services/organisations
- comparing organisations for performance assessment purposes

⁴⁷ Garling, P. Final Report of the Special Commission of Inquiry; Acute Care Services in NSW Public Hospitals, Nov 2008; Available at http://www.dpc.nsw.gov.au/__data/assets/pdf_file/0003/34194/Overview_-_Special_Commission_Of_Inquiry_Into_Acute_Care_Services_In_New_South_Wales_Public_Hospitals.pdf. Accessed on 9th May 2013

⁴⁸ The Mid Staffordshire NHS Foundation Trust Public Inquiry (2013). Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry Executive summary Available at <http://www.midstaffpublicinquiry.com/sites/default/files/report/Executive%20summary.pdf>. Accessed on 3 May 2013

⁴⁹ Garling, P. Final Report of the Special Commission of Inquiry; Acute Care Services in NSW Public Hospitals, Nov 2008; Available at http://www.dpc.nsw.gov.au/__data/assets/pdf_file/0003/34194/Overview_-_Special_Commission_Of_Inquiry_Into_Acute_Care_Services_In_New_South_Wales_Public_Hospitals.pdf. Accessed on 9th May 2013

⁵⁰ Australian Commission on Safety and Quality in Health Care (2012) Review of Patient Experience and Satisfaction Surveys Conducted Within Public and Private Hospitals in Australia. Available at <http://www.safetyandquality.gov.au/wp-content/uploads/2012/03/Review-of-Hospital-Patient-Experience-Surveys-conducted-by-Australian-Hospitals-30-March-2012-FINAL.pdf>. Accessed on 24 May 2013.

⁵¹ Coulter, A., Fitzpatrick, R and Cornwell, J. (2009). 'The Point of Care Measures of patients' experience in hospital: purpose, methods and uses'. The King's Fund. Available at <http://www.kingsfund.org.uk/sites/files/kf/Point-of-Care-Measures-of-patients-experience-in-hospital-Kings-Fund-July-2009.pdf>. Accessed on 26 April 2013

- informing referring clinicians about the quality of services
- informing commissioners and patients about the quality of services
- informing patients about care pathways
- helping patients choose high quality providers
- enabling public accountability.

Patient experience has also been found to be associated with improved health outcomes where patients' reporting good hospital care also had higher ratings of health.^{52,53}

In recent years there has been a rise in the focus on patient centred care, which involves the active involvement of patients and their families in the decision making about care and treatment options. A focus on patient experience, including measuring patient feedback, is a core part of a patient centred approach. A study assessing two similar hospitals in the US following the introduction of a patient-centred practices in one hospital found benefits to safety, efficiency and productivity metrics in the hospital introducing the patient-centred practices. This hospital demonstrated the following benefits over a five year period post the introduction of the new approach⁵⁴:

- improved average length of stay
- lower cost per case
- better use of lower-cost staff
- higher than average overall patient satisfaction scores and specific scores in seven out of nine dimensions.

Patient satisfaction versus patient experience

This section outlines the key reasons for the movement away from patient satisfaction based questions to patient experience questions in measuring patient feedback

There has been a movement away from measures of patient satisfaction in favour of approaches to measure patient experience.

Patient *satisfaction* is the process by which patients' views on their care are measured. This often included approaches where satisfaction was broadly defined and lacked recognition of the multi-dimensional facets of care or consensus about domains of care to include or weight most highly.⁵⁵ As a result of these issues, some methodological problems have

⁵² Femont, A, Cleary P, Hargraves, J, Rowe, R, Jacobson, N and Ayanian, J. (2001) Patient-centred Processes of Care and Long-term Outcomes of Myocardial Infarction. *J. Gen Intern Med*; 16:800-808

⁵³ Jha, A., Orav, E., Zheng, J & Epstein, A. (2008). Patients' Perception of Hospital Care in the United States. *New England Journal of Medicine*; 2008; 359;1921-31

⁵⁴ Stone, S., "A Retrospective Evaluation of the Planetree Patient-Centered Model of Care Program's Impact on Inpatient Quality Outcomes' Cited in Charmel, P. & Frampton S. (2008). Building the business case for patient-centred care. *Healthcare Financial Management*; Mar 2008; 62,3. P80.

⁵⁵ Coulter, A., Fitzpatrick, R and Cornwell, J. (2009). 'The Point of Care Measures of patients' experience in hospital: purpose, methods and uses'. The King's Fund. Available at <http://www.kingsfund.org.uk/sites/files/kf/Point-of-Care-Measures-of-patients-experience-in-hospital-Kings-Fund-July-2009.pdf>. Accessed on 26 April 2013

been raised with satisfaction indicators which suggest results may be prone to bias or lack specificity. These may include some of the following consequences:⁵⁶

- a limited understanding in what constitutes an overall satisfaction score due to different individual weightings on dimensions of elements of the experience
- the potential for overall scores, which tend to reflect high levels of satisfaction, to mask differences in patients' views on particular parts of their experience
- survey approaches may reflect issues identified by administrators or clinicians rather than what patients view as important to their experience
- systematic bias may be introduced to feedback associated with aged and socio-economic status, with older people and people from a lower socio-economic status being more likely to be more satisfied than younger people or people from a higher socio-economic background. Other differences may arise from differences in gender, ethnicity, clinical conditions and severity, for example.

In response to these methodological issues, some survey approaches assess actual patient experiences in order to more easily identify actions required to improve patient quality and experiences. This represents a move away from satisfaction, where broad questions like "how would you rate your care in hospital" are replaced with patient experiences, such as by asking patients to report their experiences of a particular service, clinician or specific part of their interaction with health care services. Patient *experience* questions therefore, seek to elicit information on what actually occurred to the patient, as opposed to the patient's evaluation of what occurred. Some advantages of patient experience questions over patient satisfaction questions include the:⁵⁷

- **Avoidance of potentially artificially high positive responses** by using factual questions about events and occurrences
- **Reduction of subjectivity and other potentials for bias from differences in expectations or response tendencies.** Although all responses are subjective, asking patients to provide information on an event reduces the likelihood of subjectivity. For example a patient satisfaction question might ask whether the patient was satisfied with the clinician's communication with them prior to their operation, whereas a patient experience question might ask how the clinician communicated with patient prior to the operation and how would they evaluate that experience? In the patient satisfaction question, two patients might both rate being satisfied with different amounts of contact or different ratings of satisfaction for the

⁵⁶ Aharony, L. and Strasser, S. (1993), 'Patient satisfaction: what we know about and what we still need to explore', *Medical Care Review* 50(1), pp.49-79, Carr-Hill, R (1992), 'The measurement of patient satisfaction', *Journal of Public Health Medicine* 14(3), pp.236-49.

Draper, M. and Hill, S. (1995), *The role of patient satisfaction surveys in a national approach to hospital quality management*, Australian Government Publishing Service, Canberra.

Hall, J. And Dornan, M. (1998), 'Meta-analysis of satisfaction with medical care: description of research domain and analysis of overall satisfaction levels'. *Soc Sci Med* 27(6), p.637-44,

Sitzia J, and Wood N. (1997), 'Patient satisfaction: A review of issues and concepts' *Social Science and Medicine*, 45(12), pp. 1829-43,

Williams, B. (1994), 'Patient satisfaction: a valid concept?' *Social Science and Medicine*, 28, pp. 509-516.

Cited in Pearse J (2005) Review of patient satisfaction and experience surveys conducted for public hospitals in Australia. Available at www.pc.gov.au/gsd. Accessed on 26 April 2013.

⁵⁷ Coulter, A., Fitzpatrick, R and Cornwell, J. (2009). 'The Point of Care Measures of patients' experience in hospital: purpose, methods and uses'. The King's Fund. Available at <http://www.kingsfund.org.uk/sites/files/kf/Point-of-Care-Measures-of-patients-experience-in-hospital-Kings-Fund-July-2009.pdf>. Accessed on 26 April 2013

same amounts of contact. The patient experience question would provide context for the satisfaction rating by understanding the frequency and type of communication from the clinician

- **Greater ability to interpret and respond to feedback.** Using the previous example, knowing that 25 per cent of patients were dissatisfied with their communication with the clinician prior to the operation in the patient satisfaction question would not provide the same level of ability to focus on improvements. The patient experience question, in contrast, would provide the precise details of what part of the communication process was not to the patient's satisfaction, such as the medium (telephone or face to face), message (appropriate use of language for the patient), or the timing (delivered too quickly), for example. Knowing the source of patient issues enables strategies to be put into place to more effectively improve patient care and experience.

Assessing patient experience

In this section some of the methodological considerations for assessing patient experience are discussed with respect to measuring patient experience. This section also discusses the importance of a performance management framework in establishing accountability requirements for the organisation and health service to act on patient feedback.

How to measure patient experience

The design approach to collecting information on patient feedback should focus on the purpose for which the information will be used since the design approach may dictate certain methodologies. For example, trend information requires consistency in cohorts of patients selected as well as other attributes of the survey, such as questions asked, a minimum response rates and potentially consistency in the timing that the survey is administered. Other purposes may dictate other design methods, such as understanding relationships between specific parts of the service and patient feedback, or to motivate staff groups, qualitative methods such as patient stories may be appropriate.⁵⁸ Testing whether activities are having their deigned impact on the patient experience may require a greater frequency of assessing patient feedback or if a particular patient cohort is to be tracked routine data or observation could be the appropriate design approach.⁵⁹ The design process may be multifaceted if the organisation's approach is to measure patient feedback in a number of different ways rather than selecting only one approach. Whatever design methods are deemed appropriate, these will need to confirm with the budgetary parameters of the organisation.

Sampling approach

Sampling refers to selecting a subset of individuals from within a population, such as total number of patients being treated within a healthcare organisation in a given time, to estimate characteristics of this. For the sample to be useful it must be representative of the population from which it is drawn. This involves an accurate:

- Survey population: people whose feedback is required
- Sampling frame: complete listing of the people whose feedback is required. This should exclude people outside the scope of the survey either due to their age or non-representativeness. This should also exclude deceased patients, where the survey is to occur post discharge, to avoid the distressing family members who ultimately will receive the invitation to participate in the survey
- Sample: selected individuals from the survey population who will be invited to participate in the survey.

From the sample, there will be a response rate indicating the percentage of people from the sample that completed the survey. This rate and the approach to selecting the sample require the application of appropriate statistical methods in order to ensure that the process minimises sampling error and produces a statistically representative set of information from which to use to investigate patient feedback. Guidance may also need to be sought on

⁵⁸ Coulter, A., Fitzpatrick, R and Cornwell, J. (2009). 'The Point of Care Measures of patients' experience in hospital: purpose, methods and uses'. The King's Fund. Available at <http://www.kingsfund.org.uk/sites/files/kf/Point-of-Care-Measures-of-patients-experience-in-hospital-Kings-Fund-July-2009.pdf>. Accessed on 26 April 2013

⁵⁹ *ibid*



obtaining the appropriate approval of methods employed with respect to ethics, data protection/security and other guidelines/requirements.

Quantitative approaches

Quantitative methods are concerned with numerical data outputs and that are appropriate for statistical analysis. These methods enable the analysis of responses from large samples to report on the differences or consistency of responses to each question answered, including sub groups – where statistically valid.

Where appropriate methods are used over time, quantitative approaches enable comparisons to be made between periods and also on the significance of the change. Quantitative approaches generally restrict responses by including only predetermined categories. This means that some depth in responses may be lost where response categories do not reflect the breadth of response possibilities of all respondents.

Common examples of quantitative methods for seeking patient feedback include the following:⁶⁰

- postal surveys
- interviewer administered face-to-face surveys
- interviewer administered, or automated telephone surveys
- online surveys
- surveys held on other mediums, such as hand held electronic devices or other consoles, touch-screen kiosks, pre-existing administrative functions.

Qualitative approaches

Qualitative methods are focused on providing greater depth in selecting patient feedback. This is achieved by an emphasis on words rather than numbers/predetermined response categories as options for collecting feedback. This enables a much greater level of detail and potentially insights into issues than quantitative methods but without the ease of making comparisons between the survey and over time.

Common examples of qualitative methods for seeking patient feedback include the following:⁶¹

- face-to-face interview (in depth)
- focus groups
- discovery interviews led by clinical staff
- free comments from websites, comments cards or suggestion boxes
- video boxes (on-site)

⁶⁰ Coulter, A., Fitzpatrick, R and Cornwell, J. (2009). 'The Point of Care Measures of patients' experience in hospital: purpose, methods and uses'. The King's Fund. Available at <http://www.kingsfund.org.uk/sites/files/kf/Point-of-Care-Measures-of-patients-experience-in-hospital-Kings-Fund-July-2009.pdf>. Accessed on 26 April 2013

⁶¹ Coulter, A., Fitzpatrick, R and Cornwell, J. (2009). 'The Point of Care Measures of patients' experience in hospital: purpose, methods and uses'. The King's Fund. Available at <http://www.kingsfund.org.uk/sites/files/kf/Point-of-Care-Measures-of-patients-experience-in-hospital-Kings-Fund-July-2009.pdf>. Accessed on 26 April 2013

- complaints and compliments programs
- patient diaries
- direct observation (mystery shopper)
- customer (patient) journey mapping.

When to measure patient experience

Broadly, there are three options available when deciding when to measure patients' experiences. These include at the point of contact (in hospital/at the service provider), post treatment or continuously.⁶²

At point of contact

Post treatment, or exit, surveys may be administered upon the patient's exit from hospital or after a period of care has elapsed. Administration methods can include written responses to questionnaires or comment cards. Alternatively, methods to elicit survey responses may be electronic and include hand held devices, kiosks, bedside terminals, for example.⁶³ Some common problems associated with post treatment patient feedback includes:

- the fitness of the patient, since many patients may be too ill to participate in the feedback process
- an inability to measure the complete patient journey since the patient will not have experienced post discharge care arrangements
- the potential bias from administration by staff of the healthcare organisation, which may mask negative responses. This potential problem may be mitigated by the use of volunteers and clear communication that responses will remain anonymous.

Post treatment

Options to assess patient feedback post treatment include mail, telephone or online surveys, face-to-face interviews, focus groups or patient panels.⁶⁴ Unlike at point of contact feedback, post discharge arrangements can be assessed and any potential for bias from administering the survey within the health care setting, either by employees of the organisation or volunteers, is eliminated. Additionally, the patient will have had some time to reflect on their care and recover such that they may be in a better position to provide feedback. The timing of when to request feedback needs to be balanced between ensuring that patients have had an opportunity to recover sufficiently, reflect on their experiences but for their experiences to still be current, both for recall of their care experience (*what happened*) and emotional response (*how they felt*). The use of at least two reminders is viewed as good practice in order to promote a good response rate (above 40 per cent) to self-completed mail or online surveys.⁶⁵ This may mean that the response period could be up to six weeks if the survey was administered at two weeks following the patient's discharge.

⁶² ibid

⁶³ ibid

⁶⁴ Coulter, A., Fitzpatrick, R and Cornwell, J. (2009). 'The Point of Care Measures of patients' experience in hospital: purpose, methods and uses'. The King's Fund. Available at <http://www.kingsfund.org.uk/sites/files/kf/Point-of-Care-Measures-of-patients-experience-in-hospital-Kings-Fund-July-2009.pdf>. Accessed on 26 April 2013

⁶⁵ ibid

Continuously

Patient diaries may represent one of the most complete pictures of assessing patient feedback since they present a complete picture of the patient's care journey. However they are very time consuming for the patient to complete and also for the hospital/third party to analyse the results.⁶⁶ Further, since a patient diary is dependent upon adequate literacy, they may not be appropriate for some patient cohorts. Alternatives include administering surveys along different parts of the patient pathway. The internet offers the ability for patient feedback to be collected, though unlike surveys in which respondents are chosen using appropriate statistical techniques from an eligible patient pool, there is no way of assessing the representativeness of responses and therefore an inability to benchmark or assess changes over time. Notwithstanding these comments, the medium represents a rapid way of collecting feedback.

Alternative data sources

Existing data sources may be used to support patient experience metrics which may supplement direct collection exercises. Some examples cited by the Coulter, Fitzpatrick and Cornwell in a report from the King's Fund include:

- Reporting the number and percentage of patients with terminal conditions who are able to have their reason for discharge recorded as 'to die' (or equivalent) are monitored. This can be compared to the known patient preference that people with a terminal illness prefer to die at home, though this does not happen as often as it should
- Reviewing patient 'did not attend' might provide some guidance on the convenience or otherwise of clinic times or booking arrangements.

Similarly, other examples could include the number of hospital initiated cancellations of operations or outpatient appointments, number of complaints and percentage responded to within an agreed time with the complainant or fixed time (eg 28 days), average waiting times. Additionally, this could also include reviews of management approaches to increase the organisation's responsiveness to improving the patient experience, such as consumer representatives on the Board, and access policies for special needs groups – such as visually impaired patients, intellectual disability or other physical disabilities, for example. These methods could not replace patient feedback, but offer additional perspectives of patient experience for organisations wishing to embed a patient centred approach to feedback.

What indicators to use to measure patient experience

Measuring what is important to patients should be at the heart of measuring patient feedback. This should involve using appropriate types of indicators and methods to collect feedback in order to develop approaches to improving patients' experience.

Indicators should be set up to measure an agreed set of standards, such as in the case of the NHS which is a modified version of the Picker Institute Principles of Patient-Centred Care.

Indicators are aggregate statistics based on measurements or assessments and may have targets and tolerances as reference points in order to interpret performance. These may be

⁶⁶ ibid

based on evidence-based standards, such as stroke care, or in the absence of evidence inferences of best practices based on benchmarked data from appropriate peer groups or organisational data with consultation with stakeholders.

To be meaningful, indicators should be clear about their purpose so that they are interpreted and acted upon correctly within a performance management framework. This is illustrated by way of the following example. The degree of precision of an indicator may dictate the type response based performance outside an acceptable range, from triggering an investigation in the case where an indicator is imprecise – such as an increase in readmission rates (since readmissions commonly can't differentiate at first whether the readmission is related to the previous discharge), or in the case of a precise indicator – such as the percentage of patients complaints that were responded to within a given time standard – direct accountability and attribution of responsibility.

Other important parts of an indicator are clarity with respect to the following:⁶⁷

- **Numerator and denominator:** The indicator should be clear in how it is constructed by outlining the construction using a numerator, denominator with relevant exclusions
- **Data source:** The source of the data for the indicator should be described. This could be from hospital data sets, surveys or other data sources
- **Data quality (availability, completeness and accuracy):** The indicator should also ensure that the information used is based on information that is readily available, complete and accurate. There should be clear guidance on how the indicator will manage data quality, specifying conditions under which data will be and will not be used. Where data quality is poor indicators may be constructed to assess data quality
- **Data continuity:** If the indicator is to be used over time it will be important to ensure that data sources will continue to be available. Any change to source data will need to be noted so that differences do not introduce bias into the indicator
- **Data aggregation:** The indicator should outline how data will be aggregated and whether any risk adjustment will be applied. Risk adjustment may be appropriate to account for differences in patient characteristics, such as age or gender or level or type of illness
- **Weighting of survey questions:** Individual questions within a survey may be weighted by patients to reflect what is most important to their experience. This approach is ideally suited to when indicators are aggregated across a range of measures or domains since overall measures of patient experience will reflect the weighted domain scores. The relative importance of indicators or domains can be based on a series of scales with areas of higher importance to the patient receiving a higher weighting in the aggregate indicator(s).

Performance management framework

Despite a range of patient feedback options being available to most organisations few have adequate systems for using the information in a performance management framework. An

⁶⁷ NHS Patient Experience Portal (2012). Indicators for Measuring Patient Experience. Available at <http://patientexperienceportal.org/export/document/1279>. Accessed on 30 April 2013

effective performance management framework should formalise regular monitoring and reporting within the organisation, set clear responsibilities for using the information, include triggers to act on exceptions and have governance arrangements in place to close the loop from an assurance point of view by senior leaders and board members.⁶⁸

Openness and transparency throughout the system and developing and sharing measurement and understanding of performance of individuals, teams, units and providers organisations were some of the key recommendations of the Mid Staffordshire Inquiry.⁶⁹ This included clear lines of responsibility supported by good information (*recommendation 142*), clear metrics on quality (*recommendation 143*) and ownership of quality metrics at a strategic level (*recommendation 144*). The strategic ownership of quality metrics referred to the development of indicators on quality and outcomes of care to be used throughout the health care system, from Clinical Commissioning Group's (CCG) management of health care providers' performance.⁷⁰

International best practices

In this section examples of international best practices and areas for improvement are discussed in order to highlight potential opportunities and lessons learnt from other jurisdictions.

In a review of the literature by the International Alliance of Patients' Organisations (IAPO), patient-centred indicators have been found to focus mainly on access to healthcare, support and information rather than indicators which focus on patient choice, empowerment and respect and on either hospital care and/or primary care as opposed to the health system as a whole.⁷¹ The conclusions of the IAPO are that there is a need for patient-centred indicators across the patient journey, from the identification/realisation of health need to treatment/management of disease/condition/complaint. Further research is called for to identify optimal indicators for patient-centeredness, which may include a mixture of quantitative and qualitative approaches, and a systematic way for these to be evaluated.

The number of indicators to measure should be seen in the context of the framework governing the health system, organisation, and units within the health service so that the appropriate numbers are selected and are consistent with broader measurement objectives. For example, organisation or unit level indicators may be more detailed than national level indicators, more specific to areas requiring attention and flexible with respect to timing. The appropriate number of indicators needs to be balanced so that what is measured is representative of all services or service aspects.

An option to integrate higher level indicators or a number of similar indicators is to create hierarchies where summary indicators are used at a higher level of management and are

⁶⁸ Coulter, A., Fitzpatrick, R and Cornwell, J. (2009). 'The Point of Care Measures of patients' experience in hospital: purpose, methods and uses'. The King's Fund. Available at <http://www.kingsfund.org.uk/sites/files/kf/Point-of-Care-Measures-of-patients-experience-in-hospital-Kings-Fund-July-2009.pdf>. Accessed on 26 April 2013

⁶⁹The Mid Staffordshire NHS Foundation Trust Public Inquiry (2013). Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry Executive summary Available at <http://www.midstaffpublicinquiry.com/sites/default/files/report/Executive%20summary.pdf>. Accessed on 3 May 2013

⁷⁰ The Mid Staffordshire NHS Foundation Trust Public Inquiry (2013). Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry Executive summary Available at <http://www.midstaffpublicinquiry.com/sites/default/files/report/Executive%20summary.pdf>. Accessed on 3 May 2013

⁷¹ International Alliance of Patients' Organisations (2012). Patient-Centred Healthcare Indicators Review. Available at <http://www.patientsorganizations.org/attach.pl/1438/1332/PCH%20Indicators%20Review.pdf>. Accessed on 29 April 2013



supported by detailed indicators that are useful at lower a lower level of service delivery and to explain overall changes in the summary indicator.

Research by the Picker Institute Europe evaluated 31 systematic and high-quality narrative reviews of initiatives to improve patient experience in order to identify the most effective strategies for facilitating patient-centred care.⁷² The review found that the most effective ways to improve patient experience included:

- patient-centred consultation styles and communication training for health professionals
- patient feedback (surveys, focus groups, complaints) with public reporting of performance data.

The findings from the Picker Institute Europe suggest that “coordinated investment in these areas could lead to benefits in respect of patients’ experience and may help to improve health outcomes.”⁷³ The potential benefits of coordinating investment in these activities is summarised below from the Picker Institute Europe. This is presented to highlight the role of patient feedback in integrated programs to improve patient experience.

Patient experience initiatives	Expected return on investment
Communications training for health professionals	<ul style="list-style-type: none"> ● Better interactions between clinicians and patients ● Greater patient satisfaction ● May improve patients’ knowledge and understanding of their condition. ● May lead to improvements in treatment adherence and health outcomes.
Patient-centred consulting styles and longer consultations	<ul style="list-style-type: none"> ● Patients value this approach ● May encourage better self-care
Patient feedback (surveys, focus groups, complaints)	<ul style="list-style-type: none"> ● Better understanding of priorities for quality improvement ● May help to stimulate change.
Patient-reported outcome measures (PROMs)	<ul style="list-style-type: none"> ● Improvement in diagnosis and condition management ● May help patients choose providers ● May lead to improvements in patients’ knowledge and understanding of their condition ● May help to inform treatment choices ● May lead to improvements in health outcomes.

⁷² Review of Evidence for Consumer Engagement website (2013). Picker Institute Europe. Available at www.investinengagement.info Accessed on 2 May 2013

⁷³ Review of Evidence for Consumer Engagement website (2013). Picker Institute Europe. Available at www.investinengagement.info Accessed on 2 May 2013

Public reporting of performance data

- Stimulates change at the hospital level
- May help patients choose providers

Source: *Picker Institute Europe 2013*

Research conducted for the Steering Committee for the Review of Government Service Provision in 2005 cited two key benefits of adopting international patient satisfaction survey approaches. Firstly, these methods have had considerable amounts of investment in and refining of their methods and secondly, adopting these methodologies allow the potential for international comparisons.⁷⁴

Lessons highlighted from the literature with respect to longitudinal approaches, where this is an objective, should pay careful attention to both the timing of surveys and criteria for exclusions. The timing of surveys may be an issue if not coordinated nationally since there may be systematic differences between busier winter months compared to summer months, such as during holiday periods.⁷⁵ The criteria for inclusion or exclusions needs to be consistent, even when the same survey methodology is used. Potential differences in the Australian context⁷⁶, and other jurisdictions has included variations based upon including or excluding the following groups:

- same day patients
- maternity patients – responses may be analysed separately since the experiences tend to be different to non maternity patients
- mental health patients
- children, including proxies for responses from parents or guardians and the age at which children are defined.

⁷⁴ Pearse J (2005) Review of patient satisfaction and experience surveys conducted for public hospitals in Australia. Available at www.pc.gov.au/gsd. Accessed on 26 April 2013.

⁷⁵ *ibid*

⁷⁶ *ibid*

International summary of approaches to collecting patient feedback

In this section approaches to collecting patient feedback from the US, UK, Australia and the Netherlands are discussed.

United States of America

Patient experience data are collected in the United States of America (the US) in the Centres for Medicare and Medicaid Services (CMS) and the Agency for Healthcare Research and Quality (AHRQ).

Patient feedback is collected using the Consumer Assessment of Healthcare Providers and Systems survey (CAHPS), which was developed based on Picker principles of patient-centred care at Harvard University.⁷⁷ CAHPS comprises a range of surveys to enable patients' healthcare experiences to be evaluated across hospitals, clinician groups practices and health insurance plans. Hospitals use the hospital-CAHPS (H-CAHPS) survey to measuring patient experiences across the following seven domains:

1. Communication with doctors
2. Communication with nurses
3. Responsiveness of hospital staff
4. Communication about medicines
5. Pain control
6. Cleanliness and quietness of physical environment
7. Discharge information.

The survey provides an overall assessment rating and an assessment of the likelihood or willingness of patients who participated in the survey to recommend the service to other people.⁷⁸

Comparisons are able to be made over time using the CAHPS Benchmarking Database which is the national repository for CAHPS surveys, holding over 11 years of survey data. The objectives of Hospital Compare are to help consumers make decisions about choices of where to receive their health care and encourages hospitals to improve the quality of care they provide.

The database is used to support policy by the production of annual documents such as the AHRQ's National Healthcare Quality Report and the National Healthcare Disparities Report.⁷⁹ In addition, the web-based tool 'Hospital Compare' uses information from the Hospital Outcomes of Care Measures, CAHPS and H-CAHPS surveys to provide information on hospitals' care provided to patients across certain medical conditions or surgical

⁷⁷ Australian Commission on Safety and Quality in Health Care (2010). Patient Centred-Care: Improving Quality and Safety By Focusing Care On Patients And Consumers. Available at <http://www.safetyandquality.gov.au/wp-content/uploads/2012/01/PCCC-DiscussPaper.pdf>. Accessed on 1 May 2013.

⁷⁸ *ibid*

⁷⁹ *ibid*

procedures across 4,000 Medicare-certified hospitals across the country.⁸⁰ This includes the following indicators:

Hospital Compare – Information available to consumers

- **Timely and effective care:** How often and how quickly each hospital gives recommended treatments for certain conditions like heart attack, heart failure, pneumonia, children’s asthma, and for surgical patients.
- **Readmissions, complications and deaths:**
 - How each hospital’s rates of readmission and 30-day mortality (death) rates for certain conditions compare with the national rate.
 - How likely it is that patients will suffer from complications while in the hospital.
 - How often patients in the hospital get certain serious conditions, that might have been prevented if the hospital followed procedures based on best practices and scientific evidence.
- **Use of medical imaging:** How a hospital uses outpatient medical imaging tests (like CT scans and MRIs).
- **Survey of patients’ experiences:** How recently-discharged patients responded to a national survey about their hospital experience. For example, how well a hospital’s doctors and nurses communicate with patients and how well they manage their patients’ pain.
- **Number of Medicare patients:** How many people with Medicare have had certain procedures or have been treated for certain conditions at each hospital.
- **Medicare payment:** Information about how much Medicare pays hospitals.

Source: Medicare.gov

In the US patient experience surveys are also being developed with focus on specific diseases. This includes a patient experience survey for cancer patients, supported by the National Cancer Institute and the AHRQ.⁸¹

Financial incentives are a feature in the US to promote patient feedback. This comprises incentive provided to doctors and hospitals that submit data on quality measures, including patient experience, to the CMS.⁸²

Incentives structured to support the provision of hospital data include quality, mortality, and H-CAHPS via Hospital Compare. Financial approaches include direct financial incentives for providing information, via the Reporting Hospital Quality Data for Annual Payment Update

⁸⁰ Medicare.gov (2013). Hospital Compare. Available at <http://www.medicare.gov/HospitalCompare/About/HOSInfo/Hospital-Info.aspx>. Accessed on 2 May 2013

⁸¹ Australian Commission on Safety and Quality in Health Care (2010). Patient Centred-Care: Improving Quality and Safety By Focusing Care On Patients And Consumers. Available at <http://www.safetyandquality.gov.au/wp-content/uploads/2012/01/PCCC-DiscussPaper.pdf>. Accessed on 1 May 2013.

⁸² *ibid*

Initiative (from 2008) and a two per cent penalty on income reimbursement for Medicare patients (from 2010).⁸³

Incentive arrangements for doctors who report quality measures for service covered by Medicare and Ambulatory surgical centres and other health organisations must also meet Medicare P4P reporting and performance targets. These financial incentives and requirements are provided under the *Tax Relief and Health Care Act 2006* and *Patient Protection and Affordable Care Act 2010*, respectively.⁸⁴ In addition, financial incentives are available improved coordination of patients with chronic conditions.

Private providers have also introduced financial incentives to promote a focus on meeting quality improvement goals. For one large private insurer, Blue Cross Blue Shield Massachusetts, performance based incentives were offered to providers on quality and outcome measures for both inpatient and outpatient care. The financial value was up to 10 per cent of providers' budget.⁸⁵

⁸³ Australian Commission on Safety and Quality in Health Care (2010). Patient Centred-Care: Improving Quality and Safety By Focusing Care On Patients And Consumers. Available at <http://www.safetyandquality.gov.au/wp-content/uploads/2012/01/PCCC-DiscussPaper.pdf>. Accessed on 1 May 2013.

⁸⁴ *ibid*

⁸⁵ *ibid*

United Kingdom (NHS)

The National Health Service (NHS) remains free at the point of use for anyone who is resident in the UK, though responsibility for healthcare in Northern Ireland, Scotland and Wales is devolved to the Northern Ireland Assembly, the Scottish Government and the Welsh Assembly Government respectively.

Funded by tax services, the NHS encompasses CCGs at its core whose role involves the commissioning of most health services on behalf of patients, including planned hospital care, rehabilitative care, urgent and emergency care, most community health services and mental health and learning disability services. These commissioning decisions may be procured from any service provider that meets NHS standards and costs, including hospitals, social enterprises, charities or private sector providers.⁸⁶

A feature of the NHS is the degree to which patient experience indicators are formally built into accountability frameworks which embed measurement and actions within the NHS at a sector level and organisational level since indicators should be built into contracts between CCGs and healthcare providers. This allows for further investigation of high level indicators at local levels, and the flexibility in applying potentially varied approaches to demonstrate that patients are being listened to and their feedback is acted upon.

This is enshrined in the following key operating models, frameworks and policies governing the NHS:

NHS Operating Framework

The NHS Operating Framework 2012/13 specifically states that the NHS should collect and use patient experience information in real time and use it for service improvements. NHS organisations must actively seek out, respond positively and improve services in line with patient feedback. This includes acting on complaints, patient comments, local and national surveys and results from 'real time' data techniques.

NHS Outcomes Framework

The purpose of the NHS Outcomes Framework is to provide a national level overview of how well the NHS is performing, to provide an accountability mechanism between the Secretary of State for Health and the proposed NHS Commissioning Board; and to act as a catalyst for driving quality improvement and outcome measurement throughout the NHS by encouraging a change culture and behaviour.

The NHS Outcomes Framework is structured around five domains, which set out the high-level national outcomes that the NHS should be aiming to improve. Under each domain there are a number of overarching indicators followed by improvement areas at a sub-national breakdown (regional, CCG level, local authority and provider) and equality and inequality strands at a national level (deprivation area, socioeconomic group, age, ethnicity, religion or belief, gender, disability and sexual orientation).⁸⁷ The five domains are as follows, including the relevant lower level indicators under domain 4 which relates to patient experience.

⁸⁶ NHS Choices (2013). The Structure of the NHS in England. Available at <http://www.nhs.uk/NHSEngland/thenhs/about/Pages/nhsstructure.aspx>. Accessed on 24 May 2013

⁸⁷ Department of Health (2013) The NHS Outcomes Framework 2013/14. Available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/127106/121109-NHS-Outcomes-Framework-2013-14.pdf.pdf. Accessed on 30 April 2013

Domain 1	Preventing people from dying prematurely
Domain 2	Enhancing quality of life for people with long-term conditions
Domain 3	Helping people to recover from episodes of ill health or following injury
Domain 4	Ensuring that people have a positive experience of care
Domain 5	Treating and caring for people in a safe environment; and protecting them from avoidable harm.

Source: NHS Outcomes Framework 2013/14

Domain 4	Ensuring that people have a positive experience of care
Indicators	4a Patient experience of primary care (GP services, out of hours GP services and NHS dental services) 4b Patient experience of hospital care 4c <i>An indicator on the Friends and Family test (under construction)</i> 4.1 Patient experience of outpatient services 4.2 Responsiveness to inpatients' personal needs 4.3 Patient experience of A&E services 4.4i Access to GP services 4.4ii Access to dental services 4.5 Women's experience of maternity services 4.6 Survey of bereaved carers 4.7 Patient experience of community mental health services 4.8 <i>An indicator on children and young people's experience of healthcare (under construction)</i> 4.9 <i>An indicator on people's experience of integrated care (under construction)</i>

Source: NHS Outcomes Framework 2013/14

The Department of Health uses the existing national surveys to provide data for each domain, though the Operating Framework recommends that patient feedback activities should be undertaken in addition to the annual survey to support patient improvement activities.

NICE quality standard for patient experience in Adult NHS Services

To deliver the best possible experience for patients who use NHS Services, high quality care should be clinically effective and safe. Launched in February 2012, this quality standard and accompanying clinical guidance aim to ensure that patients have an excellent experience of care from the NHS.

Future work will be supported by the National Institute for Health and Clinical Excellence (NICE) which has developed quality standards. These standards comprise a concise set of statements aimed at supporting and measuring priority quality improvements within a particular area of care. There are currently 20 standards available including common or acute conditions such as dementia, diabetes and stroke and an additional 20 standards in development. The standards do not represent a new set of targets or mandatory indicators for performance management and expected levels of achievement for quality measures are

not specified. Since quality standards are intended to drive up the quality of care, NICE suggests that levels of 100% achievement should be aspired where relevant. There is recognition that adherence may not always be appropriate in practice taking account of patient safety, patient choice and clinical judgement and therefore desired levels of achievement should be defined locally.⁸⁸

Commissioning for Quality and Innovation Scheme (CQUIN)

The CQUIN payment framework enables commissioners to reward excellence, by linking a proportion of English healthcare providers' income to the achievement of local quality improvement goals. Since the first year of the CQUIN framework (2009/10), many CQUIN schemes have been developed and agreed. Quality improvement goals cover providers of acute, ambulance, community, mental health and learning disability services and are able to build the CQUIN indicators into their contracts with CCGs. Although set locally, the CQUIN indicators must include goals in three NHS domains of quality and reflect innovation.⁸⁹

Quality Accounts

Quality Accounts aim to enhance accountability to the public and engage the leaders of an organisation in their quality improvement agenda.

Patient centeredness and in particular, patient experience is also supported in the following other policy and regulatory frameworks. This summary has been sourced from the NHS Institute for Innovation and Improvement.⁹⁰

NHS Constitution - The NHS Constitution commits the Government to providing a statement of NHS accountability. The NHS Constitution underpins patient experience; it reinforces the need for patient-centred care, where "there is no decision about me without me

NHS National Quality Board – Patient Experience Framework

The NHS National Quality Board (NOB) defined patient experience to help guide measurement across the NHS. Agreed in October 2011, the framework identifies those elements considered critical to patients' experience of NHS Services. The framework is based on a modified version of the Picker Institute Principles of Patient-Centred Care, an evidence based definition of good patient experience.⁹¹ The framework is as follows:

NHS Patient Experience Framework⁹²

- Respect for patient-centred values, preferences, and expressed needs, including: cultural issues; the dignity, privacy and independence of patients and service users; an awareness of quality-of-life issues; and shared decision making

⁸⁸ National Institute for Clinical Excellence in health Care (2013). Nice Quality Standards. Available at <http://www.nice.org.uk/aboutnice/qualitystandards/qualitystandards.jsp>. Accessed on 30 April 2013

⁸⁹ Australian Commission on Safety and Quality in Health Care (2010). Patient Centred-Care: Improving Quality and Safety By Focusing Care On Patients And Consumers. Available at <http://www.safetyandquality.gov.au/wp-content/uploads/2012/01/PCCC-DiscussPaper.pdf>. Accessed on 1 May 2013.

⁹⁰ NHS Institute for Innovation and Improvement (2013), Transforming Patient Experience, An Essential Guide. Available at http://www.institute.nhs.uk/patient_experience/guide/the_policy_framework.html. Accessed on 30 April 2013

⁹¹ ibid

⁹² ibid

- Coordination and integration of care across the health and social care system
- Information, communication, and education on clinical status, progress, prognosis, and processes of care in order to facilitate autonomy, self-care and health promotion
- Physical comfort including pain management, help with activities of daily living, and clean and comfortable surroundings
- Emotional support and alleviation of fear and anxiety about such issues as clinical status, prognosis, and the impact of illness on patients, their families and their finances
- Welcoming the involvement of family and friends, on whom patients and service users rely, in decision-making and demonstrating awareness and accommodation of their needs as care-givers
- Transition and continuity as regards information that will help patients care for themselves away from a clinical setting, and coordination, planning, and support to ease transitions
- Access to care with attention for example, to time spent waiting for admission or time between admission and placement in a room in an in-patient setting, and waiting time for an appointment or visit in the out-patient, primary care or social care setting.

Surveys of patients in acute hospitals have been mandated within the NHS since 1998. These surveys are developed with the Picker Institute in Europe and administered locally by healthcare organisations with guidance provided centrally. All results are published and used in a variety of ways to focus attention on improving patient experience, quality and safety and as a resource to patients in helping them choose where to receive their care.

Within the NHS, patient-reported outcome measures (PROMs) are used to measure the quality of care delivered to NHS patients from the patient perspective. Within the NHS PROMs include four clinical procedures and attempt to calculate the health gains after surgical treatment using pre- and post-operative surveys. The four procedures include hip replacements; knee replacements; hernia and varicose veins. PROMs have been collected by all providers of NHS-funded care since April 2009 via self completed questionnaires.⁹³ The questionnaires assess outcomes or quality of care delivered to NHS patients by assessing before and after a procedure the patient's health status or health-related quality of life at a point in time. Within the NHS there are plans to extend PROMs to other conditions,

⁹³ Health and Social Care Information Centre (2013) Patient Reported Outcome measures. Available at <http://www.hscic.gov.uk/proms>. Accessed on 26 April 2013

including long term conditions and to link outcomes to financial incentives to reward high quality care.⁹⁴

Australia

The health system in Australia shares its provision and funding by both private and public sources. This includes public funding from Medicare, the national insurance scheme levied as part of the taxation system. This funds the provision and administration of public hospital care which is free at point of service to patients and, via a patient rebate, subsidised access to out of hospital care. The public system also administers and provides other primary and community health services.

The private sector incorporates most doctors, including general practitioners and other specialists, multi day and same day hospitals, diagnostic providers and pharmacists. Patients can elect to take up private health insurance which can cover private and public hospital charges (where patients in public hospitals elect to be private), some of the medical fees for inpatient services and allied health, such as physiotherapy, and ancillary care, such as spectacles.⁹⁵

Patient experience measurement in Australia is undertaken in the context of national agreements and jurisdictional approaches within both public and private providers. The National Healthcare Agreement (NHA) sets out patient experience indicators measured annually at a jurisdictional level.⁹⁶ Australia's National Health Reform Agreement, under the Performance and Accountability Framework (PAF) requires national performance indicators, national clinical quality and safety standards developed by the ACSQHC, and new Hospital Performance Reports and Healthy Community Reports. This includes patient experience reporting by the National Health Performance Authority (NHPA) across Local Hospital Networks (LHNs) and Medicare Local (ML) sectors.

The Australian Bureau of Statistics (ABS) administers the national Health Services Patient Experience Survey encompassing some patient experience questions across hospital admissions and emergency department attendances. Since the selection process is not targeted at people attending hospital the survey is not designed for hospital level reporting.⁹⁷ The survey will be used to provide comparative information on patient satisfaction levels of patient domains of care as part of the NHA.⁹⁸

Within 11 OECD countries including Australia, the Commonwealth Fund conducts and reports patient experience surveys on a three year cycle. The Australian Commission on

⁹⁴ Coulter, A., Fitzpatrick, R and Cornwell, J. (2009). 'The Point of Care Measures of patients' experience in hospital: purpose, methods and uses'. The King's Fund. Available at <http://www.kingsfund.org.uk/sites/files/kf/Point-of-Care-Measures-of-patients-experience-in-hospital-Kings-Fund-July-2009.pdf>. Accessed on 26 April 2013

⁹⁵ Commonwealth Department of Health and Aging (2000) The Australian Health Care System. Available at [http://www.health.gov.au/internet/main/publishing.nsf/Content/EBA6536E92A7D2D2CA256F9D007D8066/\\$File/ozhealth.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/EBA6536E92A7D2D2CA256F9D007D8066/$File/ozhealth.pdf). Accessed on 3 May 2013

⁹⁶ Australian Commission on Safety and Quality in Health Care (2012) Review of Patient Experience and Satisfaction Surveys Conducted Within Public and Private Hospitals in Australia. Available at <http://www.safetyandquality.gov.au/wp-content/uploads/2012/03/Review-of-Hospital-Patient-Experience-Surveys-conducted-by-Australian-Hospitals-30-March-2012-FINAL.pdf>. Accessed on 24 May 2013.

⁹⁷ ibid

⁹⁸ ibid

Safety and Quality in Health Care and the NSW Bureau of Health Information has worked with the Commonwealth Fund to increase the survey's sample size and subject areas.⁹⁹

Survey instruments used in hospitals in Australia, by jurisdiction

The following jurisdictional analysis has been sourced from the Australian Commission on Safety and Quality in Health Care (2012).¹⁰⁰

All public hospitals administer surveys which collect patient experience and patient satisfaction information, except in Northern Territory where only patient experience indicators. Surveys are administered by a combination of either mail or Computer Aided Telephone Interviewing (CATI) methods. The coverage of the surveys is principally State-wide, except for the Northern Territory and Tasmania whose scope is by Hospital.

Private Hospitals collect either patient experience or patient satisfaction or both via mail, CATI or in house methods. The following table provides a summary of the patient experience and satisfaction surveys used in hospitals in Australia, by jurisdiction.

The opportunity to benchmark information is available within the public system in all jurisdictions other than the Northern Territory and Tasmania. Additionally, benchmarking also occurs in the larger private hospitals.

The selection criteria for identifying patients eligible to participate in the surveys is broadly similar in including patients with a minimum overnight stay in the hospital and who reside locally. Differences in selection criteria include inconsistencies in the minimum age of patients, with some excluding patients under 16 years of age compared to other which exclude patients under 18 years of age.

In its comparison of patient experience and satisfaction surveys, the ACSQHC identified ten domains of questions reported by hospitals included in the review.

Almost all (90 per cent) jurisdictions/private hospitals included in the review included domains pertaining to:

- Access/ waiting time/ admission process, information sharing/communication, physical environment and overall satisfaction.

Jurisdictions/private hospitals included in the review also reported high rates of consistency in including questions relating to the domains across the following areas:

- Involvement/ participation, privacy/ respect/ dignity and consistency/ coordination of care (80 per cent of jurisdictions/private hospitals)
- Discharge/ continuity of care (70 per cent of jurisdictions/private hospitals)

There was less consistency in the reporting of domains relating to pain control (50 per cent of jurisdictions/private hospitals) and safety/ quality, which included hand hygiene and patient identification (20 per cent of jurisdictions/private hospitals).

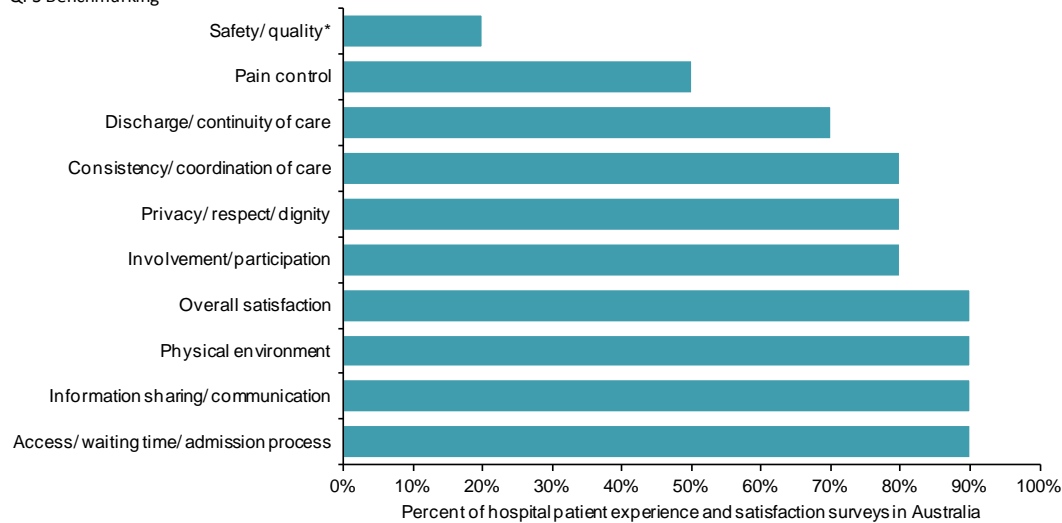
A summary of the frequency of the domains of patient experience and satisfaction in hospital surveys is included below in Figure 10.

⁹⁹ *ibid*

¹⁰⁰ *ibid*

Figure 10 Frequency of domains of patient experience and satisfaction used in hospital surveys in Australia

Assessment includes all jurisdictions for public hospitals, plus the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) for Healthscope's private hospitals and QPS, which cover a selected number of Day Hospitals administered by QPS Benchmarking



*Includes hand hygiene and patient identification

Source: Australian Commission on Safety and Quality in Health Care (2012)

The review by the ACSQHC found that some surveys in jurisdictions lacked translations to other languages which meant that they were unlikely to be appropriate for people who do not speak English or who do so with some difficulty. Two jurisdictions were reported to have approaches to overcome these barriers, including Victoria, which produces surveys in a variety of languages and the Northern Territory, which incorporates pictorial and symbols in its surveys.

Hospitals included in the ACSQHC review reported the following improvements from the administration of patient experience and satisfaction surveys. These have been grouped into clinical practices, administration processes and patient wellbeing:

Clinical practices:

- Medication safety, clinical handovers, promoting patient centred care approach, staff and patient communication/information sharing, admission and discharge process/ follow up/ continuity of care
- Appropriate storage of care plans
- Recording and cross referencing food for allergens

Administration processes

- Admission processes
- Reviewing IT systems for appointments
- Reviewing waiting times, infrastructure, planning and design of new service areas
- Management of complaints

Patient wellbeing or advocacy

- Volunteer program within aged care ward to enhance meal and nutrition experience

- Dedicated room for patient liaison officers and increased patient knowledge of health care rights and improvements in the variety of available meals

In 2010 Health Ministers endorsed the Australian Safety and Quality Framework for Health Care in 2010. The Framework has three principles at its core for safe and high quality care. These are: consumer centred, driven by information and organised for safety.¹⁰¹ There are 21 actions within the Framework to help progress the safety and quality of care provided in all healthcare settings. Its objectives are to base strategic and operational safety and quality plans on the Framework and as mechanism for prioritising activities, designing improvement goals and reviewing activities and research activities in safety and quality. In addition, the Framework should encourage partnership working and engagement between consumers, clinicians, managers researchers and policy makers about how to improve safety and quality.¹⁰² In relation to patient feedback, the Framework lists two key areas for actions:

- collecting and analysing safety and quality data to improve care
- learning from patients' and carers' experiences.

These actions areas comprise processes for defining safety and quality information to measure operational performance, clinical outcomes and the experience of patients receiving are in meaningful indicators for clinicians, managers and the executive.¹⁰³

¹⁰¹ Australian Commission on Safety and Quality in Health Care (2012) Australian Safety and Quality Framework for Health Care. Putting the Framework into action: Getting started. Available at <http://www.healthissuescentre.org.au/documents/items/2012/02/405529-upload-00001.pdf>. Accessed on 3 May 2013

¹⁰² ibid

¹⁰³ ibid

Netherlands

Following the introduction of the Dutch Health Insurance Act in 2006, patients have been given a more pivotal role in the governance of health care. In a demand-driven system, patients have become one of the market parties alongside care providers and insurers. One of the government's policy goals is to allow patients to make their own choices about their care. Central to this goal is the requirement for access to health information. The Dutch Health Care Inspectorate and the Ministry of Health, Welfare and Sports have taken various initiatives to increase health care transparency to support patients' involvement in their care.

The provision of health information includes patient experience indicators supported by the development of the Consumer Quality Index (CQI) system, introduced in 2006 to promote patient-centred care. This system is now being implemented under auspices of the Dutch Centre for Consumer Experience in Health Care in several sectors of the Dutch health care system.¹⁰⁴ The CQI is a standardised method for developing surveys and measuring healthcare quality from the patient's perspective.

The CQI methodology is based on the American CAHPS and the Dutch QUOTE (Quality of care through the patient's eyes) instruments. It entails a unique combination of questions on the frequency with which quality criteria are met and the importance of aspects according to patients.¹⁰⁵

The CQI is characterised by combining patients' experiences with the relative importance of each experience item resulting in a list of priorities for improvement of quality of care. CQIs for a variety of community services, care settings and condition-specific patients' groups have been developed, such as the rheumatoid arthritic questionnaire, the cataract questionnaire, the hip and knee questionnaire, and breast cancer questionnaire. Each patient group was found to have different priorities, which led to the need to develop specific questionnaires.

The CQI has been implemented broadly where it provides information for care providers to improve their service, for policy makers to aid in determining policy, for health care insurers to use in their negotiations with healthcare organisations and for patients to help them make informed choices between healthcare providers. Since the release of publically accessible performance data, there is some evidence of it supporting quality improvement at the hospital level.¹⁰⁶

¹⁰⁴ Netherlands institute for health services research website. Available at <http://www.nivel.nl/en/patient-experiences-and-evaluations> Accessed on 21 May 2013

¹⁰⁵ Bos et al. BMC Health Services Research 2012, 12:284 Available at <http://www.biomedcentral.com/1472-6963/12/284> Accessed on 21 May 2013

¹⁰⁶ Delnoij et al. BMC Health Services Research 2010, 10:88 Available at <http://www.biomedcentral.com/1472-6963/10/88> Accessed on 21 May 2013



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