Linking indicators and metrics to patient experience

Jennie Negus, Margaret Howat

Patient experience and quality of care have risen to the top of the NHS agenda over the last 18 months. Quality accounts (Darzi, 2008), quality innovation productivity and prevention (QIPP) (Farrar, 2009), commissioning for quality innovation (CQUIN) (Department of Health [DH], 2009), high impact actions (HIAs) (Dowsett, 2010; Dowsett and White, 2010), nurse sensitive indicators (NSI) are the national drivers that have underpinned this change. However, the new Government's White Paper, *Equity and Excellence: Liberating the NHS* (DH, 2010a) has added a sense of urgency. It states: 'Information generated by patients themselves will be critical to this process, and will include much wider use of effective tools like patient-reported outcome measures (PROMS), patient experience data, and real-time feedback' (DH, 2010).

Many trusts and organisations have already gone some way down the road towards achieving these quality aspirations. The White Paper, with the shift to clinically credible outcome measures rather than targets, along with compliance and performance regimens, will ensure that this becomes the norm rather than the exception. As an independent consumer champion, HealthWatch England, based within the Care Quality Commission, will ensure that the views and feedback from patients and carers are an integral part of local commissioning.

Patients judge the service they have received by their experience, so providing quality patient experience is vital. Through HealthWatch England, local advocacy services will support patients in making choices. Healthcare providers not only have a responsibility but an obligation to have easy to understand information available, both good and bad. The conundrum is not how to provide quality assurance, compassionate and technical care, but how to do this within an open and inclusive environment of care where the views of patients and carers can be seen and understood to be part of the organisation's aspirations and goals.

At the authors' trust, an acute foundation trust in a deprived area of central London, the approach taken has been multifaceted to take account of the local cultural and language demographics, as well as the personal and subjective nature of patient experience. The challenge has been to build a culture where everything is measured by its impact on patients, and to demonstrate the benefits that this can bring not only to patients' and carers' health and wellbeing, but also to staff health and wellbeing.

What is patient experience?

Understanding patient experience is complex. It is subjective and individual by its very nature. It is hard to make the links unless you try and understand the individual elements. It is critical that clinicians (and managers) develop empathy; 'if I were a patient I would want...', or, 'if that was my mum in that bed I would expect...'. Experience is all about emotion; it is about being anxious or reassured, being patronised or respected; feeling confused or feeling informed. Experience is personal, we tend to judge a situation on our own values and beliefs, this needs to be turned around to understand the individual patient's values and beliefs.

A starting point is for clinical leaders to use opportunities to gather patients' personal experiences of care and disseminate to staff. *Now I feel tall: What a patient-led NHS feels like* (DH, 2005) emphasises how understanding feelings and the emotional side of experience underpins patients' clinical experiences. What is seen as important and a good experience by staff, may not be seen as a good experience by patients. This was brought home to the authors at a recent trust members' meeting. A patient recounted what he considered a bad experience — having blood taken by a doctor who was competent and proficient but treated him as a task to be completed, and a good experience — having blood taken by a nurse who took four attempts but who engaged with him explaining what she was doing and treating him as a person. One comment, such as this, is picked each month at the authors' trust, and sent as an A4 poster to managers to display in their areas and to use as discussion points with staff. This stimulates, in a small way, change in culture and behaviour.

Tools to measure experience

As nurses, we are fortunate to have tools and guidance available to us from the Department of Health (DH) and the Strategic Health Authority (SHA). These encourage and help us to measure quality improvements associated with patient experience. *The Nursing Roadmap for*

Jennie Negus is Deputy Chief Nurse; Margaret Howat is Head of Patient Experience, both at Homerton University Hospital NHS Foundation Trust, London

Quality: a signposting map for nursing (DH, 2010b) sets out tools and resources that can be used to measure and demonstrate quality. Trusts throughout the country have their tools, Homerton have developed their own 'bundle' of patient experience metrics, namely:

▸▸ National surveys: the Care Quality Commission (CQC) primarily use the annual national inpatient survey, along with periodical outpatient, accident and emergency, young persons and maternity surveys. This set of surveys has been rigorously developed by the Picker Institute and is administered by an external research provider. Eighty questions track patients' journeys through a range of metrics and reports are benchmarked across the country. The results go towards the organisation's ratings

▸▸ Real-time surveys: hand-held electronic devices that patients use to answer five questions. The results are available within 24 hours on a web tool and collated and e-mailed to leads on a fortnightly basis. Results are displayed along with action plans in the clinical areas

▸▸ Message to matron: a postcard and post-box system where patients or relatives can leave a message for the matron if they miss him or her. These cards are collected daily and acted upon where indicated. A display of cards is a feature in the main entrance of the hospital

▸▸ Discharge lounge privacy and dignity survey: patients waiting for medication or transport have a short questionnaire that covers privacy and dignity offered to them. Picking up issues around mixed sex accommodation and trust and confidence in staff, this survey is collated to provide reports

▸▸ Complaints and patient advice and liaison service (PALS) enquiries: themes can be drawn from complaints and enquiries and used to understand issues occurring within service

▸▸ First Tuesday: on the first Tuesday of each month, directors are partnered with senior clinical managers and go out into the wards and departments to see how the service is running, check on performance and standards and to meet patients and staff. Using a

specifically developed tool, the teams score the service against a range of metrics, from the friendliness of the culture to cleanliness. Seeing executives and clinical staff together gives a positive message to staff and patients and the model has proved popular and valuable. Formal reports are also produced.

Clinical leadership

A significant piece of work at the authors' trust has been the development of the ward managers' key performance indicators (KPIs). These were designed to achieve ward to board reporting and accountability. Ward managers have a range of operational, clinical and patient experience targets that currently are used in their monthly 1:1s with their matrons. The matrons use the data in their 1:1s with heads of nursing and in divisional reports to the executive team. Data is provided by the owners of that information; for example, clinical incidents are obtained via DATIX incident reporting and pressure ulcers from the tissue viability clinical nurse specialist who has a bespoke database that looks not only at incidence, but also changes of grade and has patient level data. This database has proven invaluable both for the monitoring of pressure ulcers and also in developing staff expertise and awareness.

Now that this KPI model is established, from November this year ward managers will meet monthly with the chief nurse, matrons and heads of nursing and present their reports and agree required improvement measures. This shared approach not also facilitates learning across teams and services, but also personal accountability for the ward managers. Taking account is an essential attribute for clinical leadership.

Using the data

Collecting data is the easy part — the power is in how you use it. The real-time survey results are displayed publicly in each area and reports and links to surveys are available on the internet. A Survey Monkey also allows patients to feedback even if they missed the opportunity when with the trust. It is crucial for patients and visitors to know whether we are doing well or could do better. The message to matron cards, for example, are on display

and patients and visitors can see how the trust is performing, and, more importantly, whether anything is being done to improve performance.

The ward managers' achievement against their set of indicators is reported into a monthly balanced score card format and ultimately feeds up into the board reports. The authors' trust also have a patient experience committee that draws together action plans and drives the trust's improvements and includes members of the council of governors and Local Involvement Networks (LINks).

There is still a long way to go at Homerton. One of the authors' hopes is that the fledgling volunteer programme will contribute by helping patients to complete surveys, encouraging feedback and helping to implement the actions identified.

The greater challenge is on how to triangulate all this information and give a rounded picture of patient experience. Different methodologies and approaches do not always lend themselves to comparisons, yet have their own value and worth. The authors' want patients to see that the trust is actively looking at the work being done, is open and honest about what is found and where improvements are needed, and how these will be achieved. **W**ᴜᴋ

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