

Health and Community Care: Patient Experience

Better Together: Scotland's Patient Experience Programme Building on the Experiences of NHS Boards

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This paper outlines the key findings from a study examining current patient experience activities within NHS Scotland and Boards representatives' experiences of and attitudes towards patient experience. The research also examined Board representatives' expectations of the Scottish Patient Experience Programme and beliefs about patients' priorities.

Main findings

- Almost all NHS Boards were engaged in a variety of patient experience activities.
- The most common patient feedback activity was self-completion questionnaire surveys.
- Both qualitative and quantitative information were thought to be important for understanding patients' experiences.
- More interviewees preferred qualitative information than quantitative information.
- Patient feedback tools should conform to rigorous methodological standards.
- Patient surveys were the most trusted source of information about patients' experiences.
- Almost all interviewees would be interested in benchmarking their Board.
- Some were concerned that it would be difficult to make fair comparisons among different organisations.
- Many thought that the best comparator group for their Board would be the rest of the Scottish Boards, but others preferred to compare with Boards like themselves.
- The most important barriers to implementing changes as a result of patient feedback were thought to be defensiveness from clinical staff.
- Most had positive expectations of the forthcoming Patient Experience Programme.
- Interviewees were concerned that the programme would have too strong a focus on targets.
- Interviewees thought top patient priorities were *high quality safe care* and *being treated with respect and dignity*.

Background

As part of a Better Together Scotland's Patient Experience Programme, the Scottish Government commissioned an independent research organisation, Patient Perspective, to interview Chief Executives and patient involvement leads across NHS Scotland. The purpose of this work was to find out about NHS Boards' current patient experience activities; interviewees' experiences of assessing patient experience, and of acting on the findings, their opinions about different types of patient experience tools; their attitudes towards measuring patients' experiences and their expectations of the Scottish Patient Experience Programme. As part of a wider patient experience research programme, interviewees were also asked about their beliefs about patients' priorities.

Method

Thirty-five telephone interviews were carried out with representatives from all of the Scottish NHS Boards that have direct contact with patients. Interviewees included all but one of the Chief Executives from the 18 participating NHS Boards. The interviews took place between September 2007 and February 2008. All of the interviews included in this report have been checked and approved as accurate by the interviewees.

Research Findings

Patient experience activities

Almost all Boards that participated were engaged in a variety of patient experience activities. There was wide variation among Boards in the extent of their patient experience activities. Smaller rural Boards tended to be less active in this area, but this was also true of some of the larger NHS Boards.

Patient experience activities undertaken by NHS Boards included self-completion questionnaire surveys, suggestions boxes, complaints and compliments, patients' panels and forums, patients as members of governing bodies, focus groups, collecting patient stories and patient diaries. The most common patient feedback activity was self-completion questionnaire surveys. For some surveys, questionnaires were handed out on-site, while others carried out postal surveys, many of them with the help external survey contractors.

Preferences for types of patient experience information

Most interviewees said it was important to use both qualitative and quantitative information to obtain a full understanding of patients' experiences. Of those that expressed a preference for one type of information, more preferred qualitative information than quantitative information. However, most interviewees thought that a full understanding of patients' experiences could only be achieved by looking at a variety of different sources of information.

It was considered important that patient feedback tools focus on issues that are known to be important to patients. The criterion perceived to be most important for useful patient feedback tools was that they should provide actionable feedback: that is, they should provide information about what needs to be done to improve services.

Many interviewees were concerned that patient feedback tools should conform to rigorous methodological standards. For example they should use representative sampling techniques. The importance of patient feedback tools in assessing the "softer" issues of patient experiences, as opposed to clinical outcomes was mentioned by many respondents.

While there seemed to be a general overall preference for qualitative information, surveys were the single most trusted source of information about patients' experiences, followed by patients' representatives' feedback through panels and forums, feedback through suggestions boxes, letter and compliments, and formal complaints. Other trusted information sources included focus groups and patient stories. Interviewees recognised the limitations of "patient satisfaction" surveys, and they tended to prefer to use a "patient experience" question style, focussing on "what happened" to patients, rather than asking them to rate their satisfaction with services.

Learning and development of patient experience activities

When asked what they had learned as a result of implementing patient experience activities, many said that their main learning had been simply to discover the importance and benefits of doing it.

Some had changed the way they asked questions, involving patients in the development of measurement tools and focusing on experience and actionable feedback, rather than patient satisfaction. Other interviewees said they had learned the importance of following up on results by implementing quality improvements, and feeding results back to front-line staff.

Benchmarking

Almost all interviewees said they would be interested in some form of benchmarking of their Board on patient experiences, but their main concern was that it might be difficult to make fair comparisons among different types of organisation. Another concern was that benchmarks could lead to complacency if an “above average” score was thought to be acceptable, particularly if standards were generally low among comparator organisations.

Many Board representatives thought that the best comparator group for their Board would be the rest of the Scottish Boards, but an approximately equal number thought that the best comparators would be Boards like themselves (in terms of urban/rural and size). Interviewees from Special Boards tended to think it would be difficult to find a suitable comparator and some suggested comparator organisations outside Scotland.

Most would be interested in three types of comparison: comparisons among Scottish Boards, tracking changes in their own Board over time and comparing different units within their Boards. Where interviewees expressed a preference for one type of comparison, within-Board comparisons over time were the most popular, with almost half of the interviewees saying that information would be the most valuable to them. Many also thought that comparisons of different units or departments within their Board would be particularly useful for quality improvements.

Motivations and barriers to implementing patient experience activities

Almost all interviewees saw patient experience activities as central to their roles, and to the overall aims of their Boards.

The most important barriers to implementing changes as a result of patient feedback were thought to be defensiveness from clinical staff and a lack of a patient-centred culture within the Board. Many also said that capacity was an important barrier: they did not have enough time, or the right skills, or there were too many other competing priorities. Not knowing what to do with patient experience findings was also an important barrier to implementing changes.

Examples of measured quality improvements

Many interviewees volunteered interesting and inspiring examples of changes they had implemented as a result of patient feedback.

About half of the changes implemented were supported by evidence of improvement in patients’ experiences, but many responses indicated that it was not central to the Board’s culture routinely to measure the effects of quality improvement interventions.

Expectations of forthcoming Scottish Patient Experience Programme

There was wide variation in interviewees’ knowledge of the Programme, but most had positive expectations of it. They hoped it would provide rigorous, reliable tools with which to measure patients’ experiences, and that the tools would be standardised across Boards so that they could make reliable comparisons and it would provide benchmarks. They wanted support for making quality improvements and sharing best practice. Several people thought the Government programme would help them to promote the importance of patient experience.

The main concern about the programme was that there would be too strong a focus on targets at the expense of improving patients’ experiences. However, some cautiously welcomed the setting of standards for patient experience. There were also worries that the programme would impose too high a bureaucratic burden on Boards, there would be a loss of autonomy, the cost of the programme would be too high, that the methods would not be sufficiently rigorous, and that there would be unfair adverse media coverage of results.

Views on patients’ priorities

There was considerable consensus among interviewees in their views on the issues that matter most to patients. Top patient priorities were perceived to be: high quality safe care; being treated with respect and dignity; prompt access; clear communications about their condition and treatment; being involved in treatment decisions; being treated as individuals and avoiding hospital-acquired infections.

Conclusions

Patient experience activities were viewed positively by Scottish NHS Board representatives and, on the whole, Boards welcome the forthcoming Patient Experience Programme. The main concerns about the Programme were that there would be too strong a focus on targets and it would impose too great a bureaucratic burden.

There was a demand for both quantitative and qualitative information about patients' experiences. Qualitative information was thought to be particularly useful for inspiring and driving quality improvements, while quantitative

information was valued for its use in benchmarking and highlighting areas of concern or excellence. Patient surveys were the single most common patient experience activity taking place in Scottish NHS Boards.

Most Board representatives would be interested in benchmarks, either with the rest of Scotland, or with Boards similar to their own. Most would also be interested in using the results of standardised quantitative patient experience tools to compare their own organisations performance over time, and to compare different units within their Board.

This document, along with “Better Together: Scotland’s Patient Experience Programme Building on the Experiences of NHS Boards” the full research report of the project and further information about social and policy research commissioned and published on behalf of the Scottish Government, can be viewed on the Social Research website at: www.scotland.gov.uk/socialresearch. If you have any further queries about social research, or would like further copies of this Research Findings summary document or the full research report, please contact us at socialresearch@scotland.gsi.gov.uk or telephone 0131 244 7560.



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