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What makes a top hospital?

PATIENT AND STAFF EXPERIENCE

JUNE 2013

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Editorial advisory group

CHKS has worked with healthcare organisations across the UK to inform and support improvement for almost 25 years. This final report joins the first five in highlighting examples of best practice from the UK's top-performing hospitals, which we will share throughout the NHS. We would like to thank the expert panel that is advising us on these reports:

- **Helen Bevan**, NHS Improving Quality Delivery Team, NHS Improving Quality
- **Stephen Ramsden**, Director, Transforming Health
- **Ian Dalton**, President, BT Global Health
- **Simon Pleydell**, former Chief Executive, South Tees Hospitals NHS Trust

Foreword

CHKS has judged the *HSJ* Acute Organisation of the Year since its inception. In addition, CHKS celebrates success with its annual Top Hospitals programme. As a result we have seen many examples of excellence in the delivery of healthcare by acute sector organisations. The idea behind this series of reports is simply to share these examples of success in the hope that other organisations can take something from each of them.

While there are many examples in the literature of high-performing healthcare providers, they are often drawn from international comparisons where the environment is very different. These reports reflect excellence in healthcare that has been recognised within the past few years. Our aim is to share the energy and enthusiasm for providing high-quality care that we have found in the NHS in the UK.

The reports are based on the collective view of the judges of the 2010 *HSJ* Acute Organisation of the Year award, who produced an overview of what they had seen across the successful trusts (see panel below). No single trust was excellent across the board but, together, they provided a set of themes from which we can share insight.

While there may be little of surprise about the themes, it is important to recognise that they are based on current observation, so this series is not a definitive guide to good management. However, following further discussion with members of the editorial advisory group, we felt that the top hospitals had something else in common: they all put patient and staff experience at the heart of healthcare delivery. We have therefore added this final, sixth report to the series.

Much of the focus and energy for NHS leadership has understandably concentrated on making improvements in those trusts where performance is below average. This often means the best organisations are left to get on and move forward as they see fit.

Being left to make your own way can lead to isolation; it is often difficult to find out what is going on in other high-performing organisations. This series is designed to help people get a better understanding of what is happening in other trusts, by sharing case studies that highlight what organisations have already achieved.

What makes a top hospital: the observed themes

Quality and change
- Cost reduction through quality improvement
- Disciplined execution of change at scale
- Using data for improvement, not judgement

Safety
- "Getting to zero" – zero tolerance of harm
- Deliberate focus on reducing mortality and on other safety measures

Leadership
- Strong, stable leadership with continuity of chief executive
- Distributed leadership model that empowers clinical leaders and shifts power to patients and their families
- Investment in development
- The totality of the approach

Organisational culture
- Profound sense of mission and direction
- A mobilised workforce with a passion to get things right for patients
- Defining and promoting values and living them every day

External influence
- Seeing the hospital as part of the wider community
- Corporate and social responsibility
- Risk sharing with commissioners
- Learning from other healthcare providers and other industry sectors
- Comparison not just with peers but worldwide

Patient experience
- What good feedback looks like
- Why staff experience is as important
- Measuring the experience of patients and staff
- How successful organisations use feedback
- Triangulating feedback with other data

Executive summary

Many people outside the NHS are baffled that so much emphasis is placed on patient experience of healthcare. Their view, understandably, is that ensuring patients have a good experience is the lifeblood of the NHS; we shouldn't need to put so much effort into remembering this. Yet, those at the frontline and their managers know only too well how parts of the NHS body can become cut off, this lifeblood no longer circulating to them. Whether it is the numbing effect of delivering round-the-clock care, the lack of opportunity to share experiences with people who will listen, or the continuous drive to become more efficient, blockages interrupt circulation on a daily basis.

So, the reminders are worthwhile and the recent Francis Report, following the public inquiry into failings at Mid Staffordshire NHS Foundation Trust, was the biggest one yet. The report highlights vividly what happens to patient experience when kindness and compassion are absent. Indeed, restoring kindness is a theme that has been discussed many times before.

In their book *Intelligent Kindness*[1], authors John Ballatt and Penelope Campling say: "There is, perhaps surprisingly, a substantial body of knowledge to shed light on the subject of what kindness is, and what managing to be kind is about. This knowledge relates to the attitudes and behaviour of individuals, to teams and groups, to organisations and to society. It illuminates our understanding of why things go wrong, of why people behave unkindly, and also what conditions promote kindness and consequent wellbeing. It shows direct links between kindness and effectiveness and positive outcomes. It suggests virtuous circles where kindness promotes wellbeing, reduces stress and increases satisfaction for the patient, the worker and the organisation."

The question is then, how do chief executives, their boards of non-executive directors, clinical leaders and frontline staff work together to bring kindness and compassion back to the forefront of healthcare delivery?

It is a question that has occupied the thoughts of Jocelyn Cornwell, senior fellow at The King's Fund, for many years. "It is not obvious what makes large organisations become bureaucratic and at the same time dehumanising," she says. Her remedy is not a panacea but it begins with some simple steps. "You have to make staff feel like they really matter and you need to have tough conversations with people if they don't agree with putting patients first."

Patient experience is one way to determine whether organisations are really putting patients first. This report offers examples of what top hospital trusts are doing to improve in this respect. There is no template because each trust is different but there are some useful insights about measuring patient experience and how this can be triangulated with other data to get a good understanding of where the gaps can be found.

Introduction

In the maelstrom of anxiety and criticism, review and investigation, claim and counter-claim that has swirled around NHS hospitals in the past year it is a relief to be reminded that there really are such things good hospitals. Just as it is important to know what bad looks and feels like so we can improve, it's important to know what good is like so we can aspire to it.

The *What Makes a Top Hospital* reports, of which this is the sixth, do just that – provide us with examples of excellence to study and emulate. The features of good organisations that promote safety and quality in healthcare become clearer over time. Of course they all have a relentless commitment to the elimination of error, to systematic promotion of safety, and to effective internal and external communication. But those things and all the others that make for safe, effective and humane care depend on an infinite number of individual decisions and actions, which, in themselves, both create and are created by an organisation's culture.

In the year the final report of the Mid Staffordshire NHS Foundation Trust Public Inquiry was published it is impossible to ignore organisational culture. We know now that how we do things is as important as what we do in creating quality. Robert Francis QC made clear that the features of the negative culture at the hospital were professional disengagement, poor governance and indifference to the voices of patients and their families. The opposite is true in highly performing hospitals as this report shows; patients are valued and heard, professionals engage directly with patients and management, and governance is effective and reflective.

The way individuals behave, how they express their values in action, is how culture is created. The leaders we admire are those whose actions, speech and conduct reflect the values they purport to hold. That's what integrity is. A recent study conducted on behalf of the Professional Standards Authority[2] looked at the factors that influence health professionals' behaviour in the workplace. Most important seem to be the internal controls of individuals – their ability to know and do the right thing – matched with the external controls exerted by their immediate peers and managers. Strong people with good leaders create a virtuous circle of improvement. Leaders who lack integrity managing staff who lack motivation create a culture of failure.

What the top hospitals show us is that you can't create culture from the outside. Of course good organisations look outwards as well as inwards, learn and copy, change and improve. But they do so because they share and live their values and because each individual accepts responsibility for themselves and values their relationships with others.

Harry Cayton
Chief executive
Professional Standards Authority

Patient experience: the rationale for improving experience in hospitals

There is growing evidence of the association between patient experience and health outcomes in hospitals. The fact that England now has an NHS Patient Experience Framework is testament to the emphasis being placed on patient experience and the determination to make it core to healthcare delivery.

The idea of a link between patient experience and outcomes has been revisited many times by academics and practitioners. There are some notable examples. In the US, the University of Pittsburgh Medical Center (UPMC) redesigned the pathway for hip and knee procedures around the patient[3]. Patient satisfaction improved and the group recorded significantly shorter stays and lower infection rates. The patient and family-centred care methodology has been used to redesign 17 other major patient pathways in the 21-hospital UPMC group.

Hospitals in England have also shown that a focus on patient experience can improve outcomes. For example, a project to improve patient experience in the trauma pathway at the Royal Bolton Hospital NHS Foundation Trust led to measurable improvement. This included a reduction in the time it took to get patients with a fractured hip into theatre, from 2.3 to 1.7 days. Length of stay was reduced by 33 per cent and the mortality ratio by 36 per cent.

The *HSJ* Acute Organisation of the Year award winner 2012 is another case in point (see case study 1). University Hospital Southampton NHS Foundation Trust developed a Patient Improvement Framework, which includes priorities for patient experience as well as safety, clinical outcomes and operational targets linked to quality. The initiative includes an annual priority setting process for patient experience improvement and the trust has shown key performance measure improvements in areas such as same sex accommodation, pain management, infection control, nutrition, and in an overall reduction in the number of complaints received.

For some the rationale for improving patient experience is simply that it is a core function of healthcare delivery. They argue that the purpose of acute healthcare organisations is to

NHS England – *Everyone Counts: Planning for Patients*

This document was published under the NHS Commissioning Board and sets out an ambition for a health service that listens to patients. It builds on the NHS Operating Frameworks 2011/12 and 2012/13, which established eight indicator areas that will be used to monitor NHS services.

The four indicator areas that will be relevant to acute services are: patient experience of outpatient services, responsiveness to inpatient needs, patient experience of A&E services and women's experience of maternity services.

Everyone Counts: Planning for Patients says: "We will expect commissioners to work with providers to put in place mechanisms for systematically capturing real-time patient and carer feedback and comment, as well as developing plans to gather public insight on local health services. Our aim is to ensure that all NHS funded patients will have the opportunity to leave feedback in real time on any service by 2015."

look after people, and hospital trusts that weave patient experience into the fabric of their organisations will become better healthcare providers and better employers.

Jocelyn Cornwell, a senior fellow at The King's Fund and now leading the Point of Care Foundation[4] (a charity set up to continue work on patient experience started in 2007), says that for many years patient experience has been overshadowed by policy imperatives. She highlights the Francis Report into failings at Mid Staffordshire NHS Foundation Trust. "We are at last returning to understanding that if you lose sight of patient experience it is a dangerous thing to do. It's extraordinary that we should have to keep telling ourselves but what Francis says should be at the centre of everything we do and should be so forever."

CASE STUDY 1

Embedding patient experience into quality improvement initiatives

Mark Hackett, chief executive at University Hospital Southampton NHS Foundation Trust, has set a target of improving patient experience. "I want to emphasise the commitment from the entire trust to a strategy based on quality and safety that will deliver an improved patient experience," he says.

"The trust board is committed to continuously improving quality, and sees this as a top priority. It means being a world class provider of patient experience, patient safety and clinical outcomes."

In March 2007 the trust set out a Patient Improvement Framework. This framework continues to form the basis of the trust's quality governance assurance and covers four domains of quality: patient safety, patient experience, clinical effectiveness/outcomes and trust performance against national quality targets.

An annual priority setting process includes analysis of top themes for patient experience, which is informed by a wide range of opinion from patient feedback, as well as consultation with staff, members, governors and with local involvement groups such as LINKs. Performance indicators for each of the priority workstreams are set at organisational, divisional, care group and ward/department levels and monitored at each level and at organisational level.

The trust collects feedback in a number of ways including real-time inpatient surveys, which are carried out by volunteers and then used for ward to board reports. It also uses comment cards, email and a feedback facility on its website. In addition, it hosts listening events and patient feedback fora to provide opportunities for staff to hear patient feedback and stories in more detail. The trust has also started to use a single question poll via the bedside media and entertainment service. This gives instant feedback to staff about levels of patient satisfaction with care.

The trust believes that when the whole organisation focuses on a few important areas, tangible and sustainable improvements can be delivered.

So far it has been able to demonstrate key performance measure improvements in areas such as same sex accommodation, pain management, infection control and nutrition, and in an overall reduction in the number of complaints received.

The next steps are to find a way to make sense of the rich data provided by the multiple sources of feedback used, and to ensure the trust is analysing and using this data intelligently to improve services. One way of doing this is via a multichannel feedback system. The aim is to establish a better link between patient outcomes and feedback, and the trust has been piloting a system that offers this capability.

Jules Acton, director of engagement and membership at health and social care charity body National Voices, agrees. "To some extent it is strange that we have to make an effort to think about the patient experience – it should always be at the forefront of minds. On the other hand it is something that we haven't really delivered on so there is a need to keep on talking about it."

There is also a more pragmatic motive for making patient experience a priority and that is survival. As we enter a new commissioning environment, some will be keen to encourage patient choice and competition between providers. Patient experience is linked with quality of care, which in turn will become a differentiator between providers. Trusts that use quality of care to attract patients to their services are likely to secure more income and prosper. Although some in the NHS would baulk at the juxtaposition, good patient experience does translate into a marketing advantage. It is clear that top hospitals have already latched on to this.

> Our aim is to ensure that all NHS funded patients will have the opportunity to leave feedback in real time on any service by 2015. This will start with a Friends and Family Test, which will be introduced for all acute hospital inpatients and Accident and Emergency patients from April 2013, and for women who have used maternity services from October 2013.
>
> **NHS England,** ***Everyone Counts: Planning for Patients***

What does good feedback look like?

There are no hard and fast rules when it comes to monitoring patient experience; what works in one hospital trust might not necessarily work in another. That said, there are common elements that can be found in top hospitals.

Patient narratives

Many top hospitals start each board meeting with a patient story, good or bad. This helps to focus the minds of the board members on patients rather than other matters that might appear to loom large.

The benefits of bringing a patient narrative to the board are to some extent obvious. It presents the human element of healthcare in a vivid and sometimes unstructured way. Critics point out that a story in isolation does not adequately reflect the views of all users. While acknowledging this, those who favour this approach say that hearing what one patient has to say helps the board understand the patient perspective and promotes compassion.

Stephen Ramsden, former chief executive at Luton & Dunstable Hospital NHS Foundation Trust, says he is still struck by patient stories, especially when they are presented in person or in video format. "You see patient emotions laid bare and their anxieties. It gets staff thinking not just about their role but about the experiences patients are having."

Helen Bevan, of NHS Improving Quality, believes that patient narratives also serve another purpose. "What they do is send a signal from the bottom of the organisation to the top and challenge how the board is defining patient experience, and also how it takes responsibility for patient experience. I think you should always start a board meeting with a narrative." Some trusts ensure patient narratives are heard at every level in the organisation – a deliberate attempt to restore the emotional link that is often broken by the daily experience of delivering care.

Independent consultant and former trust director of service development Julie Wells says small things can often make the difference. She cites the example of whiteboards used, not just to record patient details, but as a communication tool between staff and patients and their families. There are examples of whiteboards being used as a planning tool with patients, and for patients to write up their own needs and goals. "This helps to redress the balance, promotes shared care and gives patients an opportunity to put their views and needs across," she says.

Friends and Family Test

This test involves asking patients on discharge: 'How likely are you to recommend our ward/A&E department to friends and family if they needed similar care or treatment?' There is ongoing academic debate about its usefulness and how data generated should be interpreted. However, from April 2013, it became a contractual requirement for all providers of NHS funded acute inpatient services and A&E departments to ask the question. The rationale is that the test aims to provide a simple, headline metric, which, when combined with follow-up questions, "can be used to drive cultural change and continuous improvements in the quality of the care received by NHS patients".

Given that it is here to stay, the focus should be on how to meet contractual requirements and get the most out of the test. Guidance has been issued[5] and the question is well understood.

Patients' responses use a six point scale: extremely likely; likely; neither likely nor unlikely; unlikely; extremely unlikely; and don't know. Scoring is based on a 'net promoter score' calculation: the percentage of promoters minus the percentage of detractors.[6] Expected minimum response rates are 15 per cent and patients should be surveyed on the day of discharge, or within 48 hours of discharge.

NHS England also says the question can be augmented with follow-up questions to give greater context. It has suggested: 'Please can you tell us why you would/would not recommend us to your friends and family?' to elicit a more detailed response. However, trusts have been given the flexibility to decide how to phrase subsequent questions.

Example of Friends & Family Test scoring[5]	
Extremely likely	114
Likely†	54
Neither/nor	24
Unlikely	2
Extremely unlikely	6
TOTAL OF RESPONSES	200
FFT score	**41***

* Extremely likely: 114÷200 (x100) = 57 *minus* Neither/nor + Unlikely + Extremely unlikely: 32÷200 (x100) = 16
† 'Likely' responses are excluded from the scoring

As for technology used to collect the data there are few constraints. Hospitals are exploring methods such as SMS/text, kiosks, telephone surveys and postcards.

Sam Riley, director of Insight NHS England, says: "From what I have seen, there have been different approaches to making the Friends and Family Test work, but in all the places I have been to it has clearly brought benefits."

CASE STUDY 2

Patient experience from ward to board

York Teaching Hospital NHS Foundation Trust has been working to improve patient experience and has a number of initiatives in place. Chief nurse Libby McManus works alongside a patient experience team that supports the directorate teams in the use of tools and techniques that improve patient experience.

One of the methods (in advance of the Friends and Family Test) has been to embed nursing quality metrics at ward level. Within these is a question that asks patients: 'Did you get the care you most wanted?'

"We also ask staff whether they would recommend the treatment and care they provide to friends and family," says McManus. This is fed back at ward level, triangulated with complaints and other data and reported at ward and board level.

"In addition we try to demonstrate an understanding of what matters to patients. For instance, we have been quick to identify where noise at night is affecting patients. While there are times when we can provide different environments for individual patients, feedback tells us it is important to address expectations of both patients and staff. With patients, we explain that hospitals can be noisy places and with staff we make them aware of the noise they can make and that it matters to patients."

McManus says the trust has put a great deal of effort into developing a rigorous system of leadership walk-round. The walk-rounds include all non-executive directors and local clinical management teams. "Patients are asked how they feel about the care they are getting and it seems easier for them sometimes to be more open when they are asked by people besides the nurses who are caring directly for them," she says.

More recently McManus, together with chief executive Patrick Crowley, has been taking time for an in-depth look at complaints on a weekly basis. They recognise that where patients and relatives have felt moved to write, it is important to acknowledge this as soon as possible; they want to ensure that people know how important their views are and that the concerns they express are taken seriously.

"It's important not to let the NHS complaints process drive our communication with individuals and their families. We believe that the sooner someone makes direct personal contact with a complainant, the easier it is to understand and start to remedy. Taking this feedback to staff is very powerful and we want staff to feel what it is like from the patient's perspective."

McManus says Patrick Crowley is a keen advocate of this process and talks to patients who have concerns. "He then uses this experience, whether negative or positive, to feed back to staff. On some wards we have pulled out the positive feedback and created 'word clouds' for them to use to accentuate what they are doing well. There are still many more initiatives being planned and I think we are heading in the right direction," she says.

Walsall Manor Hospital is one such trust. It has been using the Friends and Family Test for over 18 months. Response rates are up to 30 per cent and it has combined the single question with 25 others. On one ward disappointing initial results led to improvements in staffing levels and as a result, scores have risen.

Patient surveys

Surveys are another way to gather detailed feedback from patients. Patients are asked specific questions about their experience, from the way they were treated by staff to questions about noise and food. Answers are used to highlight where any problems lie and what needs to be done to improve care. Top hospitals have usually tried several different survey formats to find out what works best for their organisation.

Trusts also have access to the national inpatient survey results via the national survey coordination centre. Data covers the five inpatient survey questions used in the Commissioning for Quality and Innovation framework and provides an overall score for the provider.

The NHS patient survey programme gives the Care Quality Commission, commissioners and providers an insight into experiences of care and allows comparison between organisations and different patient groups over time.

Jules Acton of National Voices offers a reminder that the focus of surveys should to extend to carers and families. "It is really crucial that, as well as getting feedback from patients, we also include their families and the people who care for them."

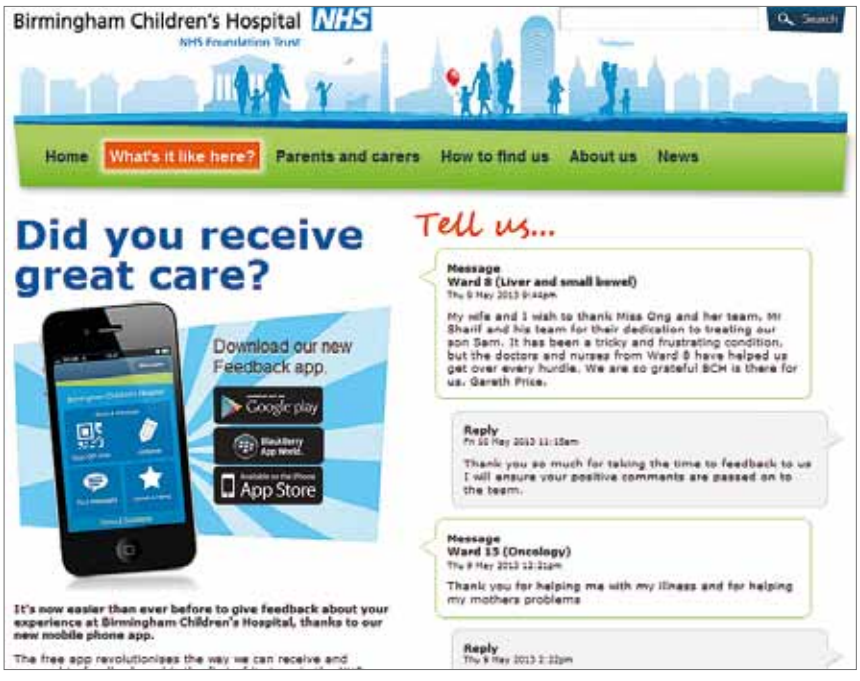
Online and social media feedback

Websites and social media are increasingly used to gather feedback and their immediacy is a major advantage. Trusts have to decide whether to use an open system (accessible by anyone) or a closed system, accessed via an email invitation or a paper invitation given at the time of appointment).

Some trusts, like Birmingham Children's Hospital NHS Foundation Trust, are leading the way. It has launched a smartphone app that allows children, young people and their families to send their comments directly to a ward at the click of a button.

Interim chief executive David Melbourne says: "We measure our success by the quality of care that we provide, the feedback that we receive and our improved patient outcomes. We don't do gimmicks – we ensure that whatever new technology we introduce is aligned with the needs of our patients.

"Introducing the feedback app was an exceptionally bold and innovative move for an NHS Trust. We welcome all feedback and most importantly we are not afraid of hearing about what we're getting wrong, simply because it gives us the opportunity to make it right."



Why staff experience is just as important

Professor Michael West has shown that in the health service, there is a clear link between staff satisfaction and patient experience.[7] "We know there is a strong link between how staff is managed and what patients say about their experience. Staff satisfaction and commitment predict patient satisfaction," he says.

"We have the data to support that staff view of their leaders is linked with patient satisfaction. When staff report that there is too much work to do, patients report that there were too few staff to meet their care needs."

The King's Fund's Jocelyn Cornwell says: "Given you accept that the fundamental purpose of healthcare acute sector organisations is to look after those who are ill and suffering, the next question is, how do you do this with such an enormously complex enterprise involving so many people with different skills and qualifications and different ways of thinking about what they are there to do?"

Top hospitals are making efforts to get feedback from staff at every opportunity and the same rules apply as with patient feedback – there is no single way to do it. Surveys and other means of feedback are useful but one approach has been cited frequently as way of helping nurses and other frontline staff to continue delivering compassionate care.

Schwartz Center Rounds® were piloted in the NHS from 2009 to 2013. This work is now being continued by the Point of Care Foundation. The Rounds provide an opportunity to discuss anonymised patient stories in confidential sessions that are open to staff throughout the hospital. Usually an hour long, each session helps staff to explore difficult feelings and stressful situations, which in turn can help tackle low morale and improve patient care.

Cornwell says: "It is only natural that every human being defends themselves against identifying with other people's pain and suffering. If you want your staff to be kind and sensitive, yet you know they are going to become hardened, then you have to create a system where they are allowed to soften. You need to give them a place where they can talk about what they do. This opportunity to reflect together on the nature of the work is very important."

Individuals who are suffering from burnout may find it more difficult to feel compassion. And the problems that a lack of compassion create for patients are obvious. "They key is to make staff feel like they really matter if you are serious about delivering patient-centred care," says Cornwell.

"Research has found that nurses who work in teams where they have some sense of family feel more able to deliver kind care. This can come down to small things like people remembering each other's birthdays or even being allowed to go home early for an event at their child's school."

Leading NHS acute trusts are working out how to target their limited internal resources to those areas where surveys and real-time feedback indicate that staff morale and wellbeing is low. These factors also be indicated by high rates of staff absenteeism and disciplinary issues. Buddying with ward managers from areas where staff morale is higher can bring help to transfer learning, bringing in a fresh approach.

Measuring patient/staff experience

The learning from top hospitals on measurement is to target areas that matter to staff and those that matter to patients. For example, at Northumbria Healthcare NHS Foundation Trust (a CHKS 40Top hospital for six years running) the patient experience team has focused on seven areas that research had shown were most important to patients. These were: consistency and coordination of care; treatment with respect and dignity; involvement in their own care; the conduct of doctors; the approach of nurses; cleanliness; and pain control.

The NHS staff survey highlights areas of importance to employees. These vary but include: clearly defined job roles; regular appraisal; being listened to by senior managers; and working in a safe environment where they will not be bullied by other staff or patients and their families.

The first step in measurement is to establish the current position. Although we have the national inpatient and staff surveys, leading trusts do not rely on this annual feedback and instead carry out more regular assessment using surveys and other feedback mechanisms.

There are aspects of a good measurement that are common among leading hospital trusts. Having dedicated staff to oversee the measurement work and provide expertise is one factor, as is protected time for review and feedback. It is also important to have good systems for managing and tracking the data collected. In addition, data should:

- be collected in as near real time as possible
- be available at a granular level so that individual clinical teams can assess their performance
- be collected along care pathways as well as for single episodes of care
- enable longitudinal comparison so change over time can be measured

For effective patient experience measurement, employees need to feel equipped and supported to work with patient feedback. This means data has to be fed back in a way that is understandable. Encouraging staff to own the feedback is also a feature of good measurement.

NHS Improving Quality (formerly the NHS Institute for Innovation and Improvement) has outlined a seven step process, from deciding aims to reviewing measures..

CASE STUDY 3

Maximising patient feedback at Northumbria Healthcare NHS Foundation Trust

Northumbria Healthcare NHS Foundation Trust covers the largest geographical area of any NHS trust in England. It employs around 10,000 staff and provides integrated health and social care across three general hospitals and seven community hospitals.

It has an established patient survey programme, which includes reviewing data from the national inpatient survey. It also commissions an annual survey of 17,000 patients with questions that mirror those in the national survey programme, with feedback received on a monthly basis. The questions are sent out in the two weeks after discharge, which Annie Laverty, director of patient experience, says avoids gratitude bias.

The trust has also recently developed an exit survey called 'Two minutes of your time' which focuses on 16 wards, with feedback given to staff within 24 to 48 hours. Consultants get individual feedback on what patients have said about them, which is then included in their appraisal. Teams and wards are also given feedback the same week, the results are shared with the business units and then reported to the board each quarter.

"This means that at team level and on every single ward, we are rating performance against the things that we know matter most to our patients. It gives us the opportunity to rank wards against Commissioning for Quality and Innovation targets and this is about shining a light on the best of our care," she says. "We learn who are best performers are and about the conditions that free them up to provide that kind of care. Equally we learn about which teams we have to support."

In total, the trust seeks the views of 25,000 patients per year with this approach and believes this goes a long way to winning the hearts and minds of staff, who are able to see how changes they make are improving patient experience.

How successful trusts use feedback

Hospital trusts that have improved patient and staff experience never rely on a single source of intelligence. They take the data they have collected and triangulate it with other information, including: patient narratives; national survey results; their own trust survey results; complaints; and incident reports. Top hospitals also triangulate data that is often more closely linked with performance, such as length of stay, rates of infection and mortality ratios.

Independent consultant Julie Wells has been working closely with Macmillan Cancer Support on a patient and staff experience initiative, which has led to the creation of the Macmillan Values Based Standard™ (see case study 4). She says: "One of the things we did in the discovery phase was use national survey data, local real-time survey data as well as interviews and workshops with patients and staff to build a triangulated picture of what patients and staff were experiencing."

Successful organisations also include patients and families in the analysis and review of feedback. Whether or not this is a formal arrangement, encouraging their active participation closes the improvement loop. The patient experience narrative then becomes:

1. Tell us what makes a difference to the care you receive
2. Now, we've listened to you, we've established some priority areas for improvement
3. This is how we plan to make improvements, can you make any suggestions?
4. We think we have improved in these areas, do you agree?
5. What else can we do to improve?

Successful organisations also have visible leaders who embody change. Boards have to demonstrate a focus on patient-centred care, so they take feedback, whether from patients or staff, seriously and put it at the heart of improvement. This helps to create a culture where staff understand that patient experience, and their own, are priorities.

Finally, feedback is communicated to staff at all levels, in a way that is meaningful. If the feedback is expressed in percentages it is also illustrated with patient narratives to help staff understand the results.

CASE STUDY 4

Improving patient and staff experience – cancer care

The Macmillan Values Based Standard™ was developed after an 18 month engagement process with more than 300 healthcare staff and people living with and affected by cancer across the country.

The Standard identifies specific behaviours that are practical things staff and patients can do on a day-to-day basis to ensure people's rights are protected across the care pathway. These behaviours are 'moments that matter' to people affected by cancer and healthcare staff. It became evident that while patients find it hard to define dignity or respect, they are very aware of behaviours that signify their opposite.

There was a high level of agreement about what the behavioural standards should look like, about what care entitlements were practical and reasonable and about where things go wrong in relation to protecting basic rights. Patients, carers and families were clear when they had not been treated with dignity and respect, and staff were acutely aware of instances in which circumstances had prevented them meeting their own vocational standards.

The MacMillan Standard is therefore focused on behaviours that improve patient experience. This is what matters to patients but it is also what matters to health professionals, reinforcing their sense of vocation and personal/professional ethics. Care in this sense is more accurately described as person-centred because it is about both staff and patients.

Evidence is beginning to suggest that patient-centred care is associated with good health outcomes and cost-effectiveness, with lower costs and shorter inpatient stays.

Conclusion

A number of hospital trusts, some mentioned in this report, have recognised that a good patient experience is not simply a by-product of quality and improvement initiatives – it is inherent in them. Each of the patient experience initiatives highlighted in the report have common elements. The first is that the chief executive, board, and senior clinical leaders all support a culture of patient-centred care. This is usually exhibited in a set of behaviours that can be found at all levels within the organisation.

Hospital trusts that aim to deliver patient-centred care make staff feel valued. Nurses and other frontline staff are much more likely to be kind and compassionate if they feel they are listened to and given time to talk about their experiences at the sharp end of care delivery.

Successful organisations ask staff and patients what matters to them and then prioritise what to focus on. The list of what matters for staff will vary from trust to trust but patients tend to want the same things – for example, to be treated with dignity and respect.

Top hospitals then put resources into measuring patient and staff satisfaction for each area of focus; they do not simply wait for the annual national surveys. Feedback is gathered in a number of ways, from telephone surveys to kiosks and smartphone apps. Dedicated members of staff are given the support to make sense of this feedback, which is then shared in an easy-to-understand way with frontline staff. Results also go to the highest level in the organisation and good leaders make it their business to follow them up personally. Very often, patient narratives are told at board meetings to help senior leaders reconnect with the human side of care delivery.

Staff and patient feedback is given context by triangulating it with other data that is collected by the organisation, whether this is related to clinical outcomes or performance measurement. This gives the organisation a 360 degree view and the ability to measure progress over time.

Finally, top hospitals all have a desire for continuous improvement. They put time into understanding what helps and hinders kindness, which in turn helps their organisation become more effective and efficient. They understand that small steps at all levels of the organisation add up to the measurable improvement in patient experience they seek.

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