

The impact of patient experience data in NHS hospitals

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Heads of Patient Experience (HOPE) Network

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- Summary of the study
 - Main findings
 - Video animation
 - Implications of findings for practice and policy

Background to the study



- Abundance of patient experience data in the NHS:
 - Friends and Family Test (FFT)
 - National Survey Programme (e.g. Adult Inpatient survey)
 - Complaints
 - NHS Choices, Care Opinion
 - Locally designed initiatives (e.g. patient stories, films, ward surveys etc)
- Limited understanding of how this data informs Quality Improvement and the changes to services as a result

Aims



- the main aim of the study is to explore and enhance the organisational strategies and practices through which patient experience data are collected, interpreted, and translated into quality improvements in acute NHS hospital trusts
 - a secondary aim is to understand and optimise the involvement and responsibilities of nurses in senior managerial and frontline roles with respect to such data
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Methods



- Ethnographic fieldwork in 5 acute NHS hospital Trusts in England over 12 months
 - Focus on Trust-wide patient experience data and the two areas of cancer and dementia care
 - Observations of meetings
 - Formal and informal interviews with staff
- Sense-making workshops with participating Trusts: one cross-site workshop in London and five local workshops at each Trust

Findings



- The multiple character of all types of patient experience data and the varied way improvement may happen
 - Specific qualities – autonomy, authority and contextualisation – contribute to linking data to quality improvements
 - Responsibility for patient experience data work largely lies with nursing staff but other professionals have important roles
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Findings (continued)



- Formalised Quality Improvement (QI) work is often very removed from ‘everyday-QI’
 - Sense-making exercises with study participants can support organisational learning
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Video animation



Implication 1

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It is not sufficient to focus only on improving the data or maximising its quantity. Trusts need to establish or encourage ways in which the three key qualities of autonomy, authority and contextualisation can be supported in relation to patient experience data and improvement work.

Implication 2

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QI practice would benefit from considering the often real-time, ‘on-the-spot’, informal nature of much improvement work and incorporating this into recognised ‘quality’ processes.

Implication 3



There exists a disconnect between, on the one hand, the work of data generation and reporting that patient experience teams do, and, on the other, actions for care improvement often undertaken by frontline staff and nursing leadership.



Implication 4



If organisations develop tools and structures that give authority, autonomy and contextualisation to staff and patient experience data, it is possible that external drivers (e.g. FFT or national surveys) come to have less of a role.



Implication 5



Sense-making workshops with participating Trusts are a valuable tool to translate research findings into action and to encourage sharing of practice within and among organisations.



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