Exploring how to improve patients’ experience in hospital at both national and local levels

A discussion on the factors that shape patients’ experience in hospital, including workplace culture, and a review of the research on interventions to improve this

INTRODUCTION
For patients in hospital, every detail of each interaction shapes the unique quality of their experience. From listening to patients, it is apparent that their experience of the hospital as an organisation and with hospital personnel is shaped to a large degree by the actions, attitudes and behaviours of individual members of staff. In turn, these are shaped by the personal experience, attitudes and values (including professional values) of the individual members of staff, and by relationships between colleagues.

The quality of the patient experience is also subtly shaped by the dynamics of the wider healthcare system and the political and social climate at the time.

Staff may be motivated and keen to provide high-quality care, but the experience of patients is not improved simply by individual acts and/or the commitment of individual members of staff.

Evidence from organisations that are renowned for the excellent quality of their care tells us that a transformation is needed in ordinary working practices and in the culture of an organisation. This is best summed up by the phrase ‘the way we do things around here’.

Transforming services or entire organisations in this way is an immense and complex task that requires serious investment at a strategic and operational level.

Recent research into the preconditions for successful social innovation shows that change occurs only when two preconditions are fulfilled (Mulgan et al, 2007): first, when the ‘felt need’ for the change (in this case, for the patient to be seen as a person) is effectively articulated as a demand, putting pressure on the system; and, second, when the demand is matched by the supply of tried, tested and effective interventions.

FRAMEWORK FOR PATIENTS’ EXPERIENCE

There are a number of frameworks for analysing the relationships between quality of care and patient safety, organisational process and structure (Bate et al, 2008; Taylor-Adams and Vincent, 2004), and wider systems (Leatherman and Sutherland, 2008).

Leatherman and Sutherland (2008) offer a simplified model of health systems in modern industrial societies that we find useful. According to them, every health system in a society such as this lends itself to analysis on four levels:

- The national level, where governments, legislators, policymakers, resource allocators and regulators function;
- The regional level, which is typically the administrative level for strategic planning and performance management, and for commissioning;
- The institutional level of hospitals and primary care organisations, the structures, processes, policies and working practices;
- The individual level, involving interactions between patients, professional caregivers and other personnel.

We retained the simplicity of the model but adapted it to focus more sharply on the factors that the research evidence suggests shapes patients’ experience in hospital.

For this purpose, we have combined the national and regional levels into a single level that we call ‘the wider healthcare system’. We have retained the institutional level and added a new, intermediate level, which we call the clinical microsystem; this might be a department, a ward or a clinical pathway (Fig 1).

Over the past decade, researchers examining the determinants of quality, particularly in relation to clinical effectiveness and patient safety (Vincent, 2001), have drawn a distinction between organisational and human factors.

Taken together, we believe that the four-level framework in Fig 1 and the concepts of organisational and human factors provide useful tools.

These can be used to make sense of the enormous variety of experiences of individual patients as they occur – be that over time, within the same clinical area or in different clinical areas, or within the same hospital or different hospitals.

Factors shaping individual interactions between patients and staff

This is the most immediate level of experience for both patients and their families. Factors that shape staff-patient interactions at this level
While patients are perhaps less at risk of insensitive treatment when they are outpatients or day patients, all institutional clinical and care settings have the potential to depersonalise and dehumanise patients and caregivers.

If we are concerned about the quality of patients’ experience in hospital, then we need to find out how, practically, we can:

- Protect patients who are particularly at risk of insensitive treatment;
- Foster and promote compassion and empathy;
- Select staff who have the capacity to see the person in the patient;
- Support staff;
- Define behaviours that are and are not admissible;
- Give staff the courage to speak up on patients’ behalf when or if they feel the quality of care has declined.

Factors at clinical microsystem level that shape behaviours

The immediate environment that shapes relationships and interactions between patients and staff is the clinical microsystem.

In general, people who work in a hospital will belong to a minimum of two teams: one consisting of their peers (for example, nurses, HCAs, junior doctors, consultants, porters, managers); and also the multidisciplinary team in the clinical microsystem – unit or department.

Many staff working in hospitals, especially in

are shown in Table 1. For all patients, the experience of entering hospital equates with powerlessness.

While even highly educated, knowledgeable, articulate people can feel powerless when they are admitted to hospital, some patients are objectively less powerful than others. This could be by virtue of youth or age, sickness, ignorance, fear, anxiety, pain, mental incapacity or as a result of physical and/or communication difficulties.

Some patients are more vulnerable for social reasons: staff may disapprove of them because they self-harm, for instance, or they may be unpopular because they are drunk, dirty, smelly, uncooperative, aggressive or noisy (Royal College of Psychiatrists, 2006; Stockwell, 2002; Jeffery, 2001).

The capacity of individual staff members to respond sensitively to all patients all of the time is finite, because they are human. Nurses, for example, can find themselves slipping into ways of doing things and behaving that are at odds with what they were taught and with their original motivations and values.

Inevitably, processes that for patients are unique, profoundly significant and highly personal – such as an emergency admission to hospital, going down to theatre or having a scan – for nurses and other staff become a

matter of everyday routine (Tallis, 2004; Strong, 1977).

Providing care exposes nurses to patients’ distress, to human suffering, disability, pain, terminal illness and death. If the feelings generated by these experiences do not receive attention, a nurse’s natural human defences against psychological and emotional disturbance will, gradually but inevitably, create ways of delivering care that protects their feelings but makes them

insensitive to patients (Menzies, 2002).

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TABLE 2. FACTORS SHAPING BEHAVIOURS AT CLINICAL MICROSYSTEM (TEAM, UNIT, DEPARTMENT) LEVEL

<table>
<thead>
<tr>
<th>Organisational factors</th>
<th>Human factors</th>
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<tr>
<td>Division of labour and skill mix</td>
<td>Leadership</td>
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<tr>
<td>Clarity/conflicts over job demarcation and professional boundaries</td>
<td>Morale</td>
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<tr>
<td>Access to information and communication technologies (ICT)</td>
<td>Communication</td>
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<tr>
<td>Operating and governance procedures, priorities</td>
<td>Experience in team</td>
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<tr>
<td>Record-keeping</td>
<td>Flexibility</td>
</tr>
<tr>
<td>Performance management</td>
<td>Team ethos, values</td>
</tr>
<tr>
<td>Deployment and capacity management</td>
<td></td>
</tr>
<tr>
<td>Staff stability, use of bank and agency staff, sickness</td>
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Source: adapted from Vincent (2001)

Evidence on the effects of nurse staffing on care delivery

Evidence from the Magnet hospitals in the US shows significant investment in nurse staffing, high ratios of qualified to unqualified nursing staff and high levels of educational attainment among nurses are all associated with high rates of patient satisfaction (Aiken, 2002).

However, investing in nurses does not automatically improve the quality of patients’ experience – especially if the nurses have other priorities.

Evidence from the Productive Ward initiative in acute care in the NHS shows that ward-based nurses in hospital spend up to 40% of their time on so-called ‘non-productive’ activities such as paperwork, fetching, carrying and searching for missing items, and shift handovers (Nolan, 2007).

It is possible to reduce the amount of time nurses spend on non-productive work, but the nursing team as a whole will not devote that time spontaneously to direct contact with patients without leadership and support from team leaders and managers.

Positive reinforcement and support for nurses and caregivers is needed to sustain the hard emotional work (sometimes called ‘emotional labour’) of caring for people who are suffering continuously.

At this microsystem level, the questions relevant to improving patients’ experience are about how to:

- Promote behaviours within teams that are associated with positive experiences for patients;
- Make communication within and between teams effective;
- Resource teams adequately;
- Deploy staff to match demand efficiently;
- Stabilise staff groups and clinical processes;
- Develop team leaders;
- Hold teams accountable for reliable, consistent quality care on every shift, every day of the week, every week of the year.

Factors at institutional level that shape behaviours

It is invariably difficult to discern the contribution that senior leaders make to well-run services. How do we identify the contribution of senior managers and directors to staff feeling able to treat ‘the person in the patient’?

Services that work well often give the appearance of being effortless. If and when problems occur, staff members act to resolve them promptly.

In contrast, when quality is poor the way in which staff deal with problems often makes the situation worse. It is at this point that poor management becomes glaringly obvious.

The actions and words of senior hospital leaders – including directors of nursing and senior nurse managers – have a profound influence on patients’ experience. They shape the culture of the hospital and the priorities of team leaders and managers further down the hierarchy. They influence how staff behave towards each other and towards patients and families, and how staff feel about the services they provide and the organisation.

According to the Healthcare Commission (2008), gross failures in service quality in trusts that have been investigated are associated with senior leaders failing to show interest in patients, and staff failing to focus systematically on service quality.

Table 3 lists the factors that protect patients and contribute to service quality at institutional level.

Shaller (2007) found that hospitals in the US with a reputation for service excellence and patient-centred care have seven success factors in common. Their senior leaders:

- Feel directly responsible for the fate of staff and patients, and take seriously their role in determining the quality of care and patients’ experience;
- Actively inform themselves about the quality of the service offered, visiting clinical units and wards, and talking to staff and patients in lifts, corridors and clinics;
- Participate in training in patient safety and quality improvement and devote time at board and committee meetings to listening to and learning lessons from individual case reviews and groups of patients and families;
- Develop and resource strategies for improving quality of care, and use communication within the organisation to make sure staff understand the strategic goals and their role in achieving them;
- Invite patients and families to participate in hospital committees and decision-making
structures at all levels;

- Use measures for service quality and have a variety of information sources about patients’ experience, including mystery shoppers, patient surveys, open days, focused discussions with groups and telephone surveys;
- Provide a supportive work environment for caregivers and pay a great deal of attention to the quality of the physical environment;
- Are innovative, encouraging the use of technology to support patients and families by providing them with information.

**THE WIDER CONTEXT**

Evidence from the Healthcare Commission (2008) and other research (Fulop, 2004) shows that trusts’ senior leaders fail more often in organisations that are subject to particular external threats, such as forced mergers and reconfigurations of services, and that have responsibility for substantial capital projects. Frequent changes at senior level are also detrimental.

Understanding the wider context that enables quality to thrive is fundamentally important if senior leaders are to run hospitals that deliver high-quality patient care.

Some decisions made at European level – such as legislation on employment and immigration, and others to do with wider changes in the economy and society – have an influence. However, hospital strategies and plans are most directly affected by national NHS priorities, the actions of healthcare regulators, the actions of performance managers in the wider system, and the financial rules and regulations governing contracts.

Over the past decade, hospitals have been under significant pressure to achieve national targets in terms of access, cleanliness and finance. Health regulators have assessed annual performance against a ‘balanced scorecard’ that includes patient survey results. However, the weight of the performance management system has been concentrated on a limited set of national priorities.

More recently, policymakers have signalled their expectations that the health service’s performance will be measured in terms of clinical outcomes and patients’ perceptions of clinical outcomes (or Patient-Reported Outcome Measures – PROMs).

They expect that the wider policy changes – patient choice, payment by results, the quality supplement that will penalise hospitals for poor quality and world-class commissioning – will deliver improvement in clinical quality and personalised care. Time will tell how effective these measures will prove to be.

The NHS Next Stage Review (Department of Health, 2008) makes quality the organising principle for the health service. By June 2010, every trust will be producing its first ‘quality accounts’, which will report on safety, effectiveness and patients’ experience of care.

It is helpful that the impact of the wider system on hospitals and the need for deep cultural change is acknowledged. Boards need to view quality improvement as their responsibility, to consider the purpose of care and the realities facing those on the ground where it is delivered, and to support the teams and individuals who are delivering it.

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**REFERENCES**


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**TABLE 3. FACTORS AT INSTITUTIONAL LEVEL NEEDED TO PROTECT AND ENHANCE SERVICE QUALITY**

<table>
<thead>
<tr>
<th>Organisational Factors</th>
<th>Human Factors</th>
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<tbody>
<tr>
<td>Set direction and priorities</td>
<td>Create an open culture in which staff feel able to voice concerns</td>
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<tr>
<td>Ensure delivery</td>
<td>Create a culture that supports effective teamworking</td>
</tr>
<tr>
<td>Regularly review clinical and patient data on quality at clinical and specialist level</td>
<td>Model enabling and supportive management styles</td>
</tr>
<tr>
<td>Maintain governance</td>
<td>Communicate interest in patients’ well-being and outcomes</td>
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</table>

Source: Adapted from Healthcare Commission (2008)