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Understanding and improving patient experience: A national survey of training courses provided by higher education providers and healthcare organizations in England

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SUMMARY

Background: Understanding and improving 'patient experience' is essential to delivering high quality healthcare. However, little is known about the provision of education and training to healthcare staff in this increasingly important area.
Objectives: This study aims to ascertain the extent and nature of such provision in England and to identify how it might be developed in the future.
Methods: An on-line survey was designed to explore training provision relating to patient experiences. To ensure that respondents thought about patient experience in the same way we defined patient experience training as that which aims to teach staff: 'How to measure or monitor the experience, preferences and priorities of patients and use that knowledge to improve their experience'. Survey questions (n = 15) were devised to cover nine consistently reported key aspects of patient experience; identified from the research literature and recommendations put forward by professional bodies. The survey was administered to (i) all 180 providers of Higher Education (HE) to student/qualified doctors, nurses and allied health professionals, and (ii) all 390 National Health Service (NHS) trusts in England. In addition, we added a single question to the NHS 2010 Staff Survey (n = 306,000) relating to the training staff had received to deliver a good patient experience.
Results: Two hundred and sixty-five individuals responded to the on-line survey representing a total of 159 different organizations from the HE and healthcare sectors. Respondents most commonly identified 'relationships' as an 'essential' aspect of patient experience education and training. The biggest perceived gaps in current provision related to the 'physical' and 'measurement' aspects of our conceptualization of patient experience. Of the 148,657 staff who responded to the Staff Survey 41% said they had not received patient experience training and 22% said it was not applicable to them.
Conclusions: While some relevant education courses are in place in England, the results suggest that specific training with regard to the physical needs and comfort of patients, and how patient experiences can be measured and used to improve services, should be introduced. Future developments should also focus, firstly, on involving a wider range of patients in planning and delivering courses and, secondly, evaluating whether courses impact on the attitudes and behaviors of different professional groups and might therefore contribute to improved patient experiences.

Introduction

Internationally, patient experience of healthcare is increasingly being recognized as essential to providing high quality health care services (Robert and Cornwell, 2012). In England, the Department of Health and National Quality Board has published the NHS Outcomes Framework (which includes "ensuring that people have a positive experience of care") (DH, 2012a) and NICE (National Institute for Clinical Excellence) have published standards for improving patient experience, it is therefore timely to examine issues of the provision of professional training and education in relation to patient experience. At present little is known internationally about how education providers and health care organizations train students and staff in recognizing the importance of patient experience; which aspects of patient experience are covered in any existing

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courses; or whether patients are involved in designing and delivering them.

The main determinants of patient experience are thought to be closely related to the behaviors and actions of healthcare staff – for example whether they show compassion, empathy and responsiveness to a patient's needs, values and preferences (Institute of Medicine, 2001) – the quality of patient experience has also been linked to organizational factors, including service co-ordination and integration of care (Curry, 2006; Coulter et al., 2009). The provision of sufficient information, good communication and patient education are also important influencing factors (Shaller, 2007), as are aspects of physical need and comfort, as well as emotional support (such as relieving fear and anxiety). A broader aspect is 'seeing the patient as an individual person' (Goodrich and Cornwell, 2008) and involving them and their families or carers in decisions about their own treatment or care (Gerteis et al., 1993; Cotterell and Morris, 2011).

The role of healthcare staff (and other caregivers) in the patient experience improvement process is potentially significant; however, while healthcare organizations are initiating a number of strategies to improve care and respond to changing regulatory and policy requirements, many clinicians practicing in them have not received training on quality and safety as a part of their formal education (Jones et al., 2009; Wong et al., 2010). Training healthcare staff may be important not only to ensure that they have the skills needed to improve the quality of healthcare, but also to enhance their motivation to improve patient-centered care. There is some evidence internationally that training students and health professionals in quality improvement techniques may improve knowledge, skills and attitudes. Care processes may also be improved in some instances. However, the impact on patient health outcomes, resource use and the overall quality of care remains uncertain (The Health Foundation, 2012). There is also a notable deficit of teaching or learning about 'patient experience' in quality improvement training.

The importance of orientating professional practice to patients' needs is emphasized by the eight principles for patient-centered care advocated by the Picker Institute (Picker Institute, 1987). The case for expanding and prioritizing components of quality improvement training that directly affect patients is strong (Van Hoof and Meehan, 2011). In the UK, a leadership and change management-orientated approach to quality improvement training means that the focus is sometimes on making one-off improvements (Pingleton et al., 2010), rather than training professionals and students to take a patient-focused approach to continuously improving healthcare practice and services (Shortell et al., 1998). Nurse education in particular has tended to emphasize quality and safety competencies (Armstrong et al., 2009; Barton et al., 2009), which may not adequately the multiple dimensions of patient experience.

The provision of pre-qualification training or in-service, continuing professional education of healthcare staff that focuses on understanding and improving patient experience is important to the delivery and development of health care services for three main reasons. Firstly, many healthcare systems internationally aim to deliver patient-centered care (Shaller, 2007), which has been described as 'care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions' (Institute of Medicine, 2001). The challenges in delivering and improving patient-centered care include finding ways to capture and make sense of patient experience (Gerteis et al., 1993) and to translate these into service improvements (Goodrich and Cornwell, 2008). Secondly, there is a widespread movement in professional practice, service development and research towards increased patient involvement (also sometimes referred to as public involvement or service user involvement (Cotterell and Morris, 2011)). Patient involvement is founded on the idea that patients can, and should, have a say in how care and services are delivered. It also recognizes that patients (carers and their families) have the most direct experiences of services and can provide insights into how care or services might be improved (Curry, 2006). Thirdly, patient experience has become an essential indicator of the performance of healthcare systems worldwide (Coulter et al., 2009). It is now common to judge quality of care not only by measuring clinical effectiveness and safety, as outlined in government policy (Department of Health 2008, 2012b); but also by gathering the views of patients in receipt of care (Tsianakas et al., 2012), and in relation to what patients, their families and carers need (Shaller, 2007; Goodrich and Cornwell, 2008). The implications for healthcare staff are that they need to understand the organization of care processes from patients' perspectives as well as the meaning of healthcare experiences for patients; and be capable of contributing to the collection of patient experience data, assessing its importance and implications, and acting on the results in a systematic way (Coulter et al., 2009).

An important influencing factor on the significance given to training in patient experience is the extent to which national bodies responsible for regulating education of healthcare professionals include the concepts of patient-centered care and patient experience in their standards. In England the General Medical Council (2006, 2009) sets out six duties of a doctor three of which relate to having regard for individual patients, these are: 'make the care of your patient your first concern', 'treat patients as individuals and respect their dignity', and 'work in partnership with patients'. The Academy of Medical Royal Colleges (2009, 2010) has helped to develop a Medical Leadership Competency Framework for all stages of a doctor's career and a Medical Leadership Curriculum for postgraduate and specialty training that reflects wider responsibilities, including 'a vitally important fact that doctors have a direct and far-reaching impact on patient experience and outcomes'. Similarly, the Nursing and Midwifery Council (2008) sets out four standards of conduct, performance and ethics, of which the first is: 'make the care of people your first concern, treating them as individuals and respecting their dignity'. The Health Professions Council (2008) is responsible for allied health professionals and sets out 14 standards, the first two of which are: 'you must act in the best interests of service users', and 'you must respect the confidentiality of service users'.

In the broader context of such codes of conduct, the aim of this study was to draw together information about the extent and nature of patient experience education and training currently available to healthcare students and staff in England. The main focus of this paper is on registered health professionals but the study also included administrative staff and managers, who are often included in training offered by NHS organizations. We also included staff groups that are less often thought of as contributing to patient experiences: for example, porters, care assistants, estates, information technology and other non-clinical support staff.

Methods

The study used survey methods to gather information on the extent and nature of patient experience education and training, including undergraduate and postgraduate programs, in-service training and continuing professional development (CPD). We identified a potential sample of 180 HE organizations which undertook medical, nursing and health care professional training, 19 Deaneries and 390 NHS organizations (Table 1).

In developing the survey questionnaire we sought to identify key aspects of 'patient experience' in relation to education and training and to assess whether these aspects are currently included in the education and training available to NHS staff. Although the term 'patient experience' is a well known term, it could potentially have different meaning to different education providers. We employed a definition in the survey to ensure that respondents thought about this term in the same way, and to limit the chance of inter-respondent variation. The definition we adopted was 'How to measure or monitor the experience,