Setting Levels of Ambition for the NHS Outcomes Framework

A technical annex to support Developing our NHS care objectives: A consultation on the draft mandate to the NHS Commissioning Board

Chapter 6: Ensuring that people have a positive experience of care

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Domain 4 – Ensuring people have a positive experience of care

Introduction

6.1 This chapter sets out our proposals for calculating a level of ambition for domain 4: 'Ensuring people have a positive experience of care'. The proposed methodology is summarised in the executive summary and explained in detail in chapter 2.

6.2 In this chapter, we review available data for each indicator. A 'notes' section highlights some aspects which may merit further consideration. The chapter illustrates a range of factors that may affect outcomes (we use the term 'drivers' to describe these). In some cases, we refer to findings from academic literature. Such citations are not intended to be a guide to clinical practice and should not be taken as official endorsement by the Department of Health.

6.3 We produce 'current practice projections' where data are available. The purpose of these projections is explained in the executive summary and in Chapter 2. They are not forecasts of performance – rather they represent benchmarks for assessing the likely NHS contribution to improving outcomes. After producing a projection, we then consider what scope there is for the NHS to improve outcomes measured by individual indicators within available resources.

6.4 Finally, sections 3 a and b provide examples of how these areas of possible improvement could be aggregated and used to inform a level of ambition that is set for each domain. It is important to note that this section is a partial assessment at this stage. It illustrates how we might set levels of ambition. We intend to quantify what might be possible to achieve at a national level. It would then be for the NHS Commissioning Board to decide how to meet that level of ambition.

6.5 Our partial assessment is based on building up a picture of what might be possible based on considering individual indicators. Our aim is to have a level of ambition that represents the goal of the domain as a whole – therefore we are clear that we may need to make some additional broader assumptions.

6.6 As indicated earlier in the document, this material is an analytical work in progress. It is being published in the interests of transparency, to outline our proposals, and to invite comments. Levels of ambition will be included in the final mandate.

(1) Domain 4 overview and metric of improvement

6.7 This domain comprises ten indicators of patients' responses to surveys regarding their experience of care and access to care.

6.8 The measures of patient experience are derived from surveys of patients and service users covering the following care areas:

- GP services (4a.i)
- Out of Hours Services (4a.ii)
- NHS Dental Services (4a.iii)
- hospital care (4b)
    - outpatient care (4.1)
    - inpatient care (4.2)
    - A&E services(4.3)
    - maternity services (4.5)
- end of life care (4.6)
- mental health services (4.7)
- children's experience of care (4.8)

6.9 The indicators in domain 4 can be combined together to provide an overall aggregate measure of experience for service users. Using established sources in this way provides a good meaningful source of data, with a robust baseline from which to measure progress.

6.10 As the draft mandate explains, we will be introducing an additional new measure for this domain along with patient experience of primary care and patient experience of hospital care. This new measure is the 'friends and family test', enabling us to understand whether patients would recommend their hospital to friends and family as a high quality place to receive treatment and care.

6.11 We will need to undertake work to establish meaningful data and a robust baseline. The Friends and Family Test will be implemented for acute inpatients and A&E from April 2013. We will also be undertaking further work to establish the feasibility and costs of implementing it more widely.

6.12 To adjust the aggregated scope for improvement to avoid double counting, indicator 4.2 is excluded from the calculations of the overall scope for improvement because responsiveness to in-patients' personal needs is reflected within overarching indicator 4b. Nevertheless, indicator 4.2 is reported separately as it relates to aspects of inpatient care where there is considered most scope for improvement.

6.13 Access to patient care is measured by indicator 4.4., for access to (i) General Practice and (ii) Dental services.

6.14 Together, the overarching indicators (4a and 4b) and the complementary improvement indicators (4.1 to 4.8) provide a picture of the NHS' contribution to improving the experience of care, including access to care.

6.15 The proposed aggregate metric of Domain performance is constructed by averaging the experience of care rating for each of the care areas.

6.16 However, service areas vary in their scale of impact (for example, inpatient care includes a higher volume of operations or invasive procedures than outpatient attendances). A weighting will be used when aggregating the scores across the different indicators as a proxy for the relative impact of different contacts. (See Table 4.2 in section 3a at the end of this chapter.

6.17 We have considered cost-weighting, which is a crude approximation to the relative importance of an episode of care, and the importance of the experience of that episode to the patient; we have also considered weighting on the basis of duration of contact, but that gives intuitively disproportionate weight to inpatient episodes. Conversely, giving equal weight to each indicator gives too little weight to the importance of inpatient episodes, and is also inappropriately dependent upon the arbitrary construction of survey groupings. Further work on appropriate weighting will be undertaken.

6.18 Assessing progress over time, and projecting it forward, is confronted by possible sources of bias if different cohorts of patients have different expectations of service quality, or the same patients change their expectations over time.

6.19 Patient experience with NHS services, if objectively measured should be wholly within the control of the NHS. However, the indicator scores might be partially affected by previous experience with care services in social care and public health. Other factors such as the patients' sense of engagement with the system, their feelings of gratitude and perceptions of relative equity might inhibit their reporting negative experiences of the care received and promote positive evaluations. This may be influenced by demographic variation in the patient groups being more inclined to give positive responses. This effect is corrected where possible by standardising (adjusting) the indicators. These biases should be limited because individual survey questions are focused on objective aspects of experience.

(2) Domain 4 Indicator Trends, Explanations, Projections and Scope for Improvement

6.20 This section sets out for each indicator, or set of indicators:

a) Recent Trends and Explanations

b) Current Practice Projections

c) Scope for improvement

6.21 Current practice projections are predicated upon consideration of the influence of drivers on outcome. From our understanding of the relative contribution of different factors to outcomes, current-practice projections for each indicator are made on the assumption that the quality of the NHS contribution to outcomes is maintained at the same level as in the base-year, 2012/13 (see discussion in Chapter Two, section ii).

6.22 The NHS Operating Framework 2012/13 aims at driving up the quality of patient experience and clearly states (paragraph 2.27) national surveys should be supplemented by local surveys, real-time feedback and complaints data – and the results published - and that the NHS needs to improve services in line with patient feedback[2]. These processes provide the basis for improvement is more difficult, and different approaches will be explored during the consultation period.

Indicator 4a: Patient Experience of Primary Care

i. GP services
ii. GP services
iii. NHS Dental services

Outcome sought	Improvement in patients' experiences of GP services, GP Out of Hours services and NHS Dental services.
Indicator definition	Percentage of respondents reporting "Very Good" or "Fairly Good" to each relevant question from the GP Patient Survey (for adults aged 18 and over)

(a) Indicator 4a: Recent Trends and Explanations

6.23 There is currently no trend to report. The indicator will be based on aggregated data from two collections each year from 2011/12. The first wave for 2011/12 covers July to September 2011. Data for wave 2 will be published on 14 June 2012, and the first release of the indicator should be published soon after that.

Breakdown by question (for wave 1 only)

6.24 For patients using primary care services from July to September 2011, over 80% reported a good experience with GP services and NHS dental services and around 70% with GP Out of Hours services – see table 4a.a.

Table 4a.a Percentage of respondents reporting good experience with their GP services (weighted)

	Question	Good
GP services	Q28. Overall, how would you describe your experience of your GP surgery?	88%
GP Out of Hours services	Q41. Overall, how would you describe your experience of out-of-hours GP services?	71%
NHS dental services	Q45. Overall, how would you describe your experience of NHS dental services?	83%

Source: GP Patient Survey[1]

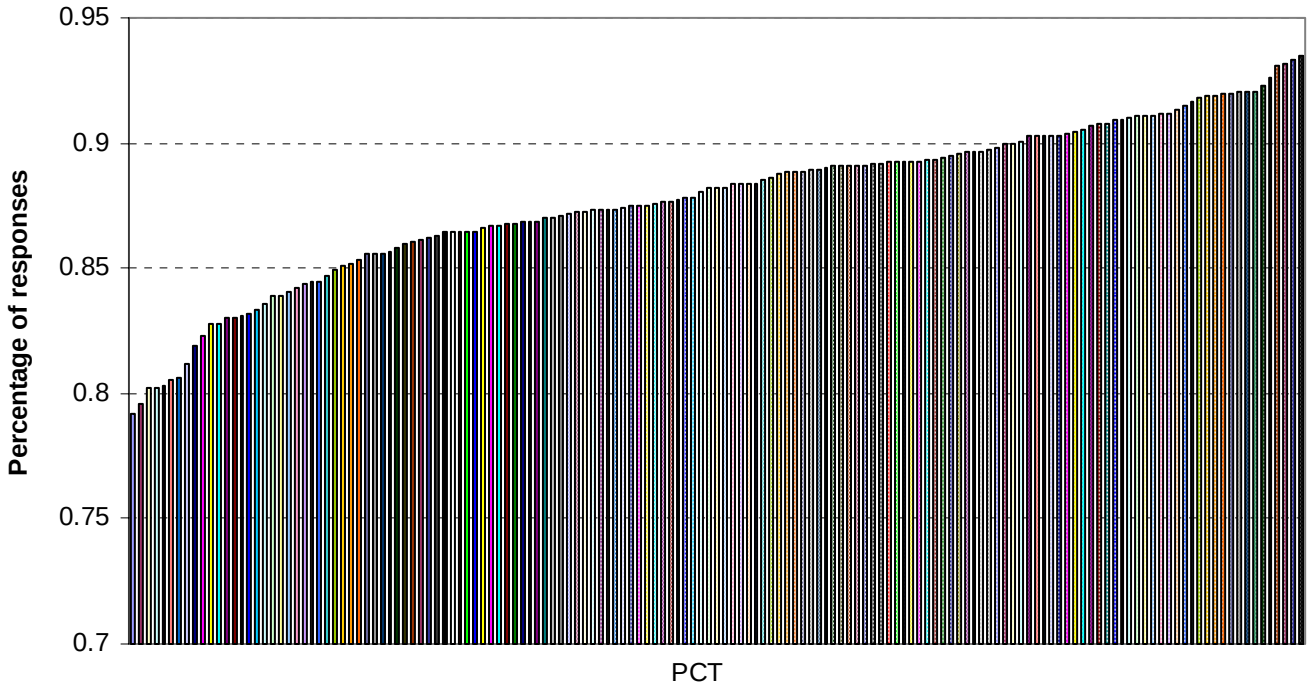
Notes: 1. The percent of respondents reporting a good experience is the sum of the percentage of patients reporting "Very good" and "Fairly good" experience

2. The GPPS weighted results adjust for unequal probability of selection for any differential non-response by age, gender and practice and, since 2011/12, by neighbourhood statistics such as ethnicity and deprivation. More details on the weighting of the GP Patient Survey can be found at http://www.gp-patient.co.uk/faq/weighting/

Breakdown by Primary Care Trust

6.25 Across Primary Care Trusts (PCTs), the percentage of respondents reporting a good experience with their GP surgery ranges from 79% to 93%, with the lower quartile of 86%, median of 88% and the upper quartile score of 90% – see figure 4a.a.

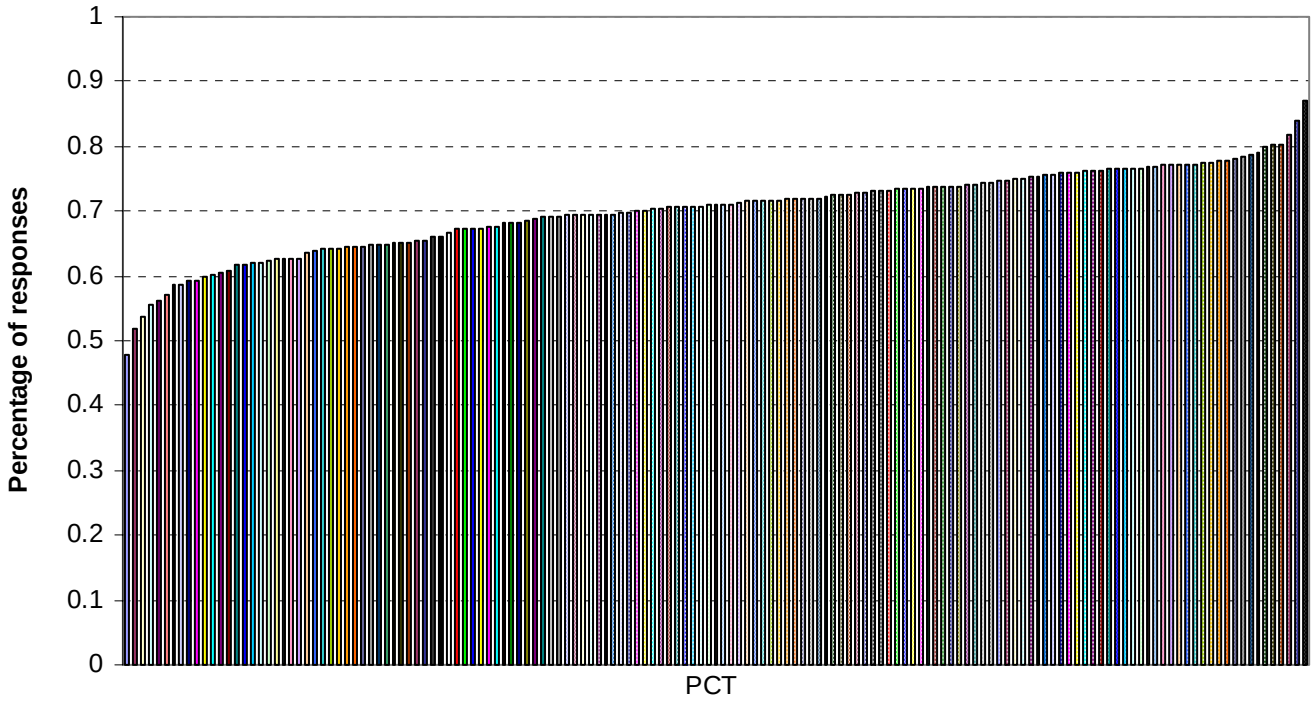
Figure 4a.a Percentage of respondents reporting good experience with their GP practice by PCT, from low to high score



Source: GP Patient Survey1

6.26 Across PCTs, the percentage of respondents reporting a good experience with GP Out of Hours services ranges from 48% to 87%, with the lower quartile of 65%, median of 71% and the upper quartile score of 75% – see figure 4a.b.

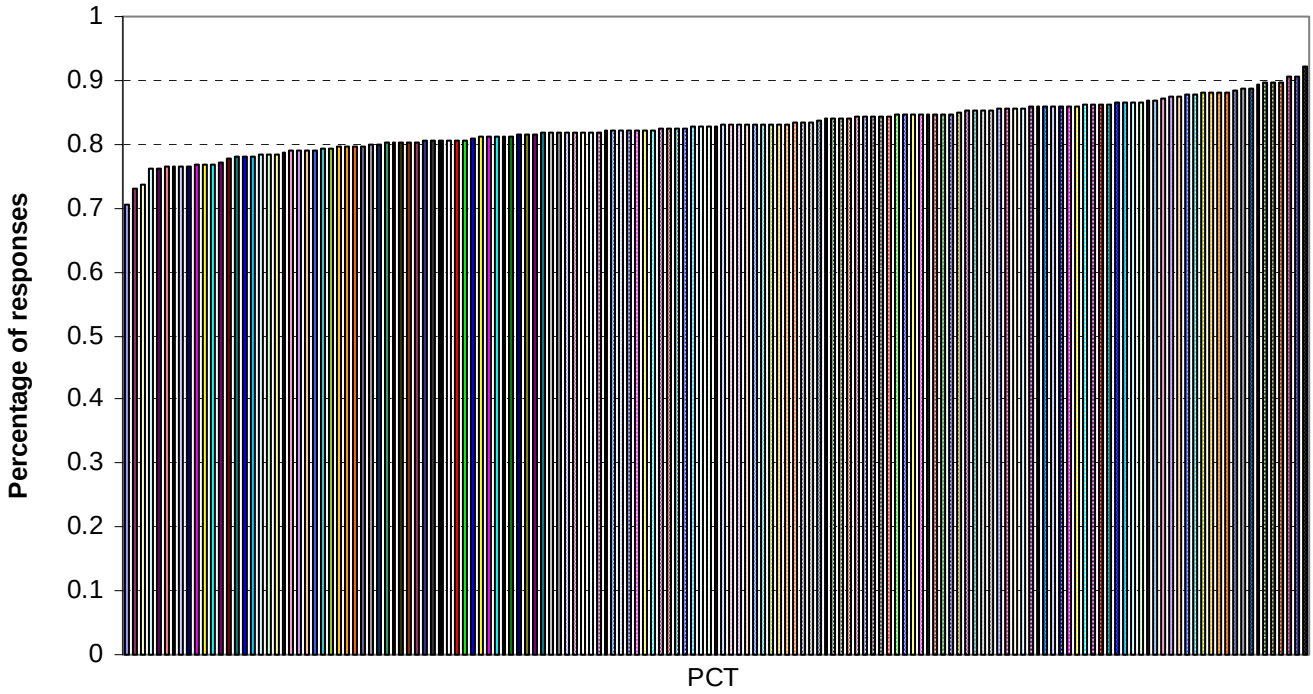
Figure 4a.b Percentage of respondents reporting good experience with GP Out of Hours services by PCT, from low to high score



Source: GP Patient Survey1

6.27 Across PCTs, the percentage of respondents reporting a good experience with NHS Dental Services ranges from 71% to 92%, with the lower quartile of 80%, median of 83% and the upper quartile score of 86% – see figure 4a.c. These responses are those who have tried to get an NHS dental appointment in the last two years and were selected to the GP Patient Survey sample. Therefore, these respondents should not be seen as a representative sample of NHS Dental patients.

Figure 4a.c Percentage of respondents reporting good experience with NHS Dental Services by PCT, from low to high score



Source: GP Patient Survey1

International position

6.28 Not available.

Possible sources of bias

6.29 As outlined in section (1), there is potential for results to be influenced by changes in gratitude bias and patients' and service users' sense of engagement and involvement with the system.

(b) Indicator 4a: Current Practice Projections,

6.30 To be decided.

(c) Indicator 4a: Scope for Improvement

6.31 The factors considered to define the scope for improvement are described at the beginning of section (2).

6.32 The transformation of urgent and emergency care services aims to maximise the number of instances when the right care is given by the right person at the right place and right time for patients. Rather than 'educating' patients about where it is appropriate for them to go, it focuses on designing a simple system that guides them to where they should go.

6.33 As initiatives in this workstream should ensure that more people are seen in the correct place first time, there could be an improvement in patient experience as a result.

6.34 The development of a set of clinical quality indicators to measure the quality of urgent care services is currently in the pipeline. This is part of the 'coherent 24/7 urgent care service' to which the Government is committed. The aim of these indicators is to measure and improve the quality and consistency of care delivered by out of hours services, as well as throughout the whole urgent and emergency care (U&EC) system generally. The indicators will also aim to encourage greater integration of U&EC services to provide better clinical outcomes and improved patient experience.

6.35 Furthermore, the NHS 111 service, which will be rolled out across the whole country by April 2013, will make it easier for the public to access urgent healthcare and also drive improvements in the way in which the NHS delivers that care. The easy to remember, free to call 111 number will clinically assess callers during their first contact and direct them to the right local service, first time, thus improving patient experience.

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4b – Patient experience of hospital care

Outcome sought	Improvement in patients' experiences of NHS inpatient care.
Indicator definition	This Overall Patient Experience score is the average (mean) of five domain scores, and each domain score is the average (mean) of scores from a number of selected questions in the CQC Inpatient Services Survey. Scores are standardised by age and gender.

(a) Indicator 4b: Recent Trends and Explanations

6.36 Patient experience of NHS adult inpatient services showed virtually no change overall in 2011/12 compared to 2010/11. The overall score was 75.6 out of 100, which indicates a level of experience that patients might rate as good, on average ('good ' is reflected with a score of about 60, a score of about 80 suggests 'very good) 1 – see table 4b.a.

6.37 Inpatient experience was around 76 out of 100 each year from 2003/04 to 2011/12 and the scores show no consistent improvement or deterioration in reported patient experience – see table 4b.a and figure.4b.a.

6.38 To account for differences in reported experiences across age, sex and method of admission to hospital (elective or emergency), the results for each trust, which are averaged to produce the national score, are standardised for these factors.

Table 4b.a Adult inpatient survey - National scores (scores out of 100)

	2003/04	(…)	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2011/12 95%CI
Overall score	75.7		76.2	75.7	75.3	76	75.6	75.7	75.6	+/-0.16

Source: NHS IC Indicator Portal

Legend: CI – Confidence Interval. Confidence intervals provide a range of values within which we are confident that the true value is likely to lie. The national indicator score for 2011/12 has a confidence interval of plus or minus 0.15. This means that the true value is likely to lie in a range from 0.16 below our estimate to 0.16 above it.

Note: There was no data collection for 2004/05.

Breakdown by experience set

6.39 The overall patient experience score is the average (mean) score of five sets of scores, and each set score is the average of scores from a number of selected questions in the Care Quality Commission adult inpatient services survey.

6.40 Across sets, the findings from the 2011/12 survey are (see table 4b.b and figure 4b.a)) [1]:

- There was a decline in the experience score of 'access & waiting' (down from 84.2 to 83.8 from 2010/11 to 2011/12). This was largely a result of a decreased score for a question about whether patients felt that they waited a long time to be admitted to hospital. This score captures information about how long patients reported they waited for treatment (higher scores for shorter waits), hospitals not changing admission dates, and length of time patients waited when they arrived at hospital.
- There was no significant overall change in 2011/12 for 'Safe, high quality, coordinated care'. This score captures information about not being given contradictory messages by staff, not being delayed when discharged from hospital and being given information about any dangers related to medicines.
- Experience of 'better information, more choice' did not change from 2010/11 to 2011/12 and improved slightly from 2009/10 to 2010/11 from 66.8 to 67.2. This score was between 67.2 and 69.1 out of 100 each year from 2003/04 to 2011/12.
- There was no significant overall change in 2011/12 for 'Building closer relationships'. This score captures information about communication between patients and their doctors and nurses; whether patients understand what they were told, and avoiding situations where staff talk in front of patients as if they were not there.
- There was no significant overall change in 2011/12 for patient experience of 'clean, comfortable, friendly place to be'.
- There are no consistent trends for any of these sets of questions.

6.41 Scores for different aspects of care cannot be compared directly. Individual patient responses to each question are given a score out of 100, using a pre-defined scoring scheme. The most positive answer always receives a score of 100, and the most negative gets a score of 0. Intermediate responses (for example those saying that a patient 'sometimes' experienced a particular issue) are given scores between 0 and 100, again on a pre-defined scale.

6.42 There are two reasons why scores for different questions cannot be compared directly:

- Scores are not comparable across questions. There is no reason to suppose that a score of 50 on one question is directly equivalent to a score of 50 on another question.
- The relative value judgement applied to each question is not necessarily equivalent for patients. For example, being treated with respect is not necessarily equivalent to feeling that doctors seemed to work well together.

6.43 This does not call into question the results. This is a valid and typical approach to scoring social surveys, but the implication is that scores from one question should not be directly compared with scores from another.

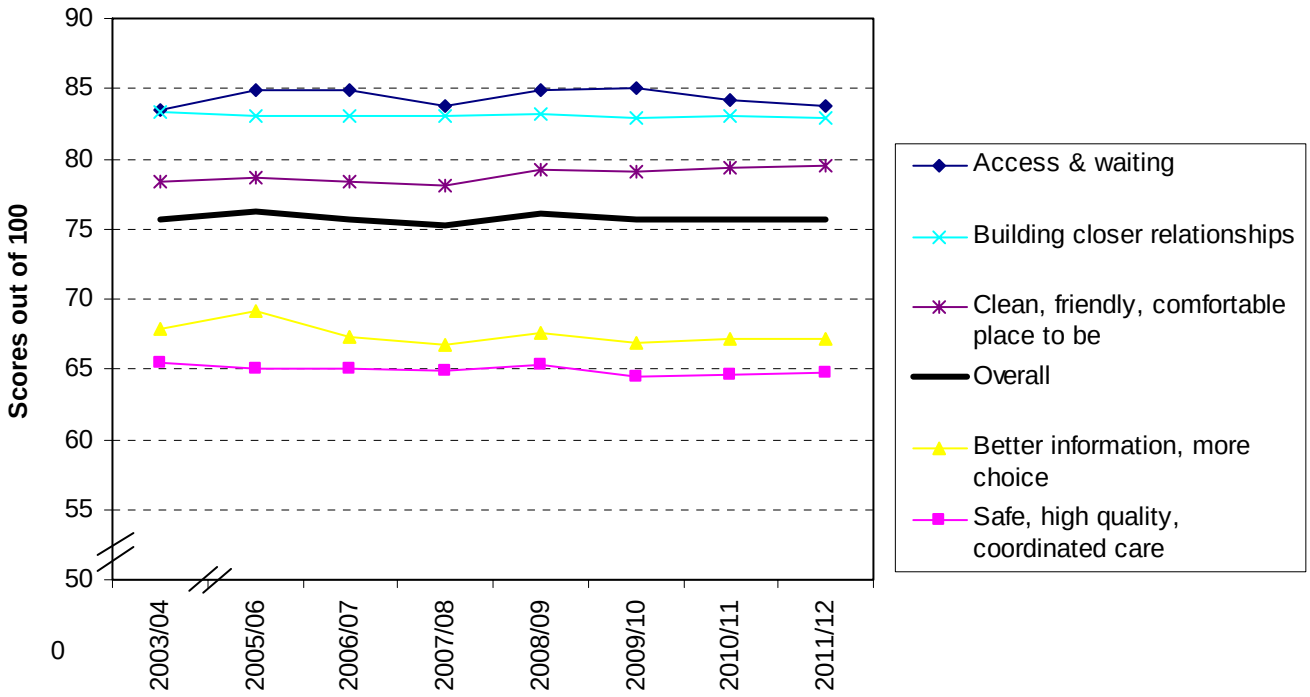
Table 4b.b National inpatient experience scores by set (scores out of 100)

	2003/04	(…)	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2011/12 95% CI
Access & waiting	83.5		84.9	84.8	83.8	84.9	85	84.2	83.8	+/-0.19
Safe, high quality, coordinated care	65.5		65.1	65.1	64.9	65.3	64.4	64.6	64.8	+/-0.23
Better information, more choice	67.9		69.1	67.3	66.7	67.7	66.8	67.2	67.2	+/-0.26
Building closer relationships	83.3		83.1	83.1	83	83.2	82.9	83	83	+/-0.16
Clean, friendly, comfortable place to be	78.4		78.6	78.4	78.1	79.2	79.1	79.3	79.4	+/-0.14

Source: DH[1]

Legend: CI – Confidence Interval. Confidence intervals provide a range of values within which we are confident that the true value is likely to lie. For example, the 'Access & waiting' set has a confidence interval of plus or minus 0.19. This means that the true value is likely to lie in a range from 0.19 below our estimate to 0.19 above it.
Note: There was no data collection for 2004/05.

Figure. 4b.a National inpatient experience scores (scores out of 100)



Source: DH[1]

Breakdown by Strategic Health Authority (SHA)

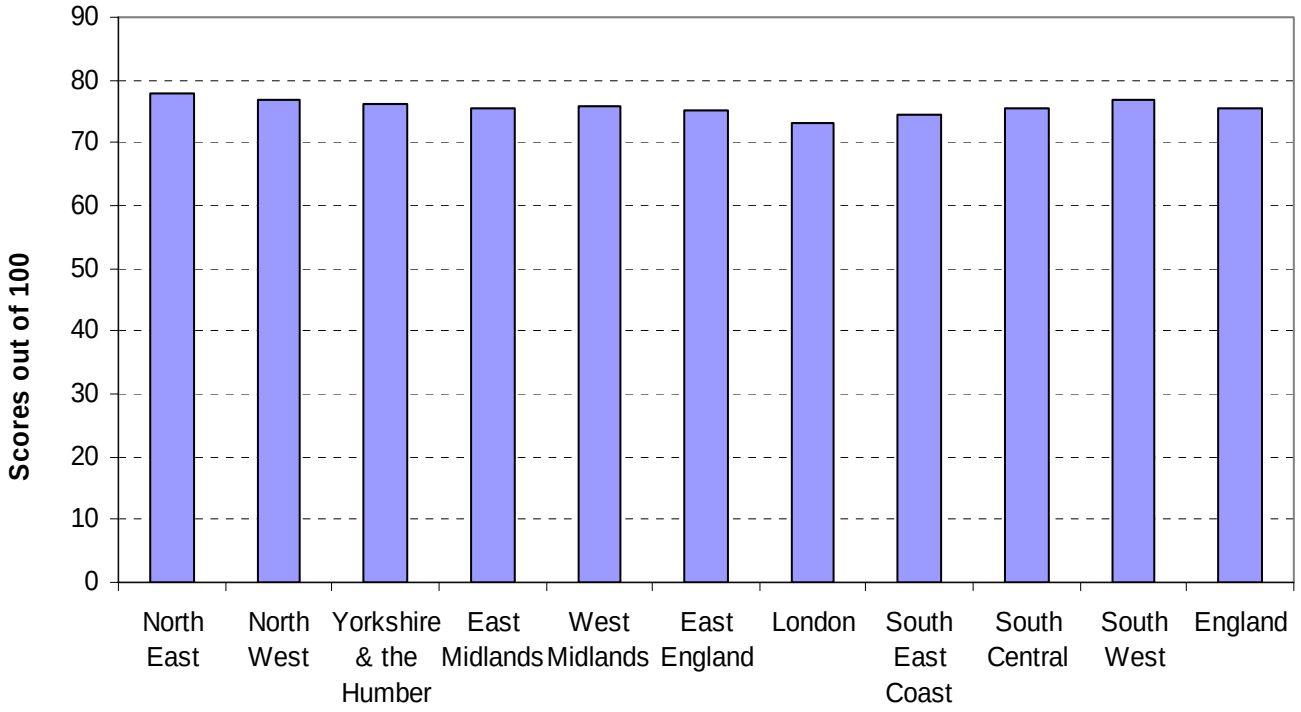
6.44 Overall inpatient experience in 2011/12 seems highest in the North West, North East and South West and lowest in London – see Table 4b.c and Figure 4b.b.

Table 4b.c. 2011/12 SHA average of inpatient experience scores

	North East	North West	Yorkshire & the Humber	East Midlands	West Midlands	East England	London	South East Coast	South Central	South West	England
Access & waiting	85.5	84.4	84.8	84.8	84	83.7	81.7	81.7	84.2	84.8	83.8
Safe, high quality, coordinated care	68.8	66.5	65.5	63.3	65.5	63.8	61.6	63.7	64.1	66.9	64.8
Better information, more choice	70.7	67.9	66.6	67.3	67.4	66.9	65.7	66	67.2	68.2	67.2
Building closer relationships	83.6	84.6	83.8	82.8	83.3	82.2	79.7	82.5	83.5	84.9	83
Clean, friendly, comfortable place to be	80.3	80.7	79.9	79.9	79.8	79.5	77.6	77.9	79.1	80	79.4
Overall	77.8	76.8	76.1	75.6	76	75.2	73.2	74.4	75.6	77	75.6

Source: DH[2]

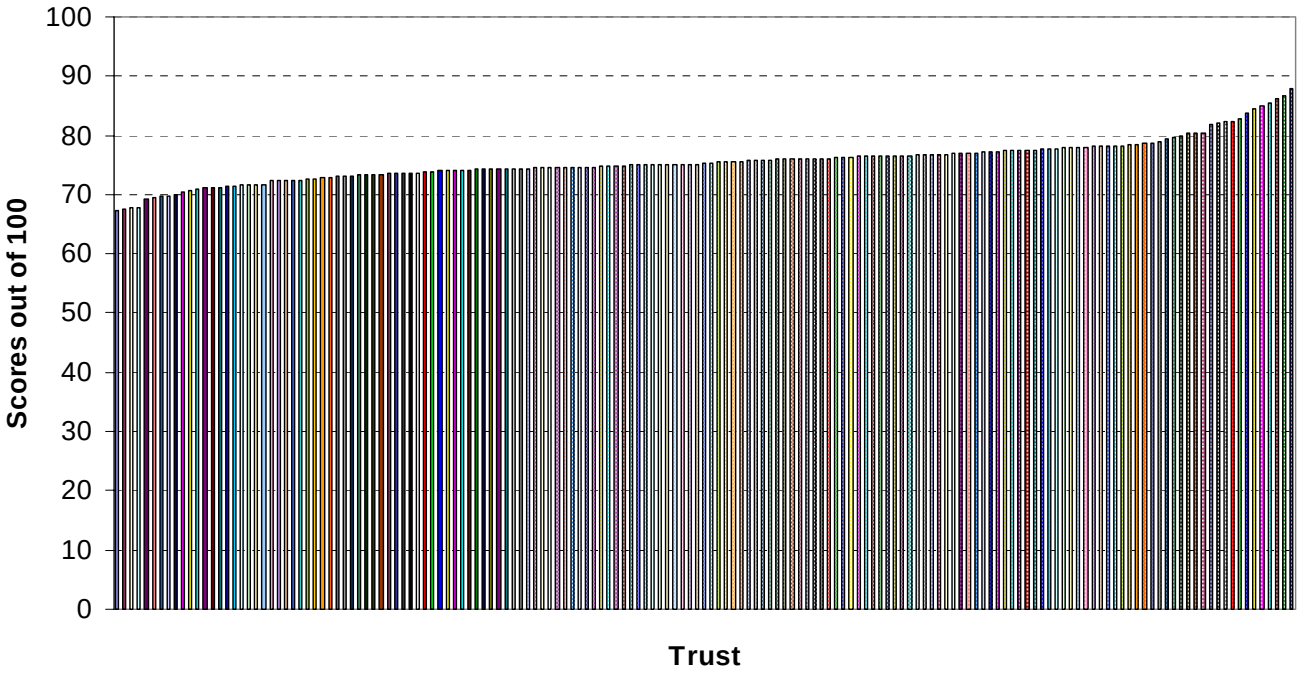
Figure. 4b.b 2011/12 SHA average of inpatient experience scores



Source: DH[2]

6.45 Across trusts, scores range from 67.4 to 87.8, with the lower quartile of 73.6, median of 75.3 and the upper quartile score of 77.3 – see Figure 4b.c.

Figure 4b.c Overall scores for each Trust, from low to high score



Source: DH

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International position

6.38 Not available.

Notes:

- Why are patient experience scores so stable over time?

6.46 These surveys are based on very large sample sizes, so at national level the results have very small confidence intervals (this means: the results are very accurate and give a good indication of experience for the whole population of patients). The degree of random variation is therefore minimised and the indicators provide a very good measure of actual levels of experience within the NHS. We therefore postulate that scores have been stable over time because patient experience has been stable over time.

6.47 Speculatively, changes in users' expectations might affect patient experience scores. For example, if users expect a higher level of service delivery, then they might report their experience as good since it aligns with their expectations, rather than as 'very good'. This being the case, then improvement in services focussed at improving patient experience might not reflect changes over time if users' expectations adjust to better delivery of services, and therefore, will contribute to explaining why scores are so stable over time. However, we should stress that there is no evidence showing that patient expectations have changed.

6.48 Another factor explaining why scores are so stable over time pertains to the way scores are affected by policy initiatives. Results from past surveys indicate that the surveys are sensitive to change where there are coherent national improvement strategies aimed at specific policy areas. Such policies are not necessarily identified as patient experience measures. The survey questions that feed in to this indicator are selected from a broader set of question scores, taken from a very wide ranging questionnaire. Examination of broader results across the full patient survey programme shows that:

- In outpatient care, the question about how long patients reported they waited showed a substantial improvement as 18 week Referral to treatment (RTT) was rolled out (from 76.9 out of 100 in 2004/05 to 83.4 in 2009/10).

- In inpatient care, scores for same sex accommodation improved significantly as policy to address Mixed Sex Accommodation was rolled out (A separate publication by the Care Quality Commission shows that the percentage of patients sharing mixed sex accommodation when first admitted fell from 24% in 2008, to 18% in 2009, and now to 14% in 20103).

6.49 Taken together, these indicate that the surveys can measure change, provided there has been a substantive change to measure.

Possible sources of bias

6.50 There is potential for results to be influenced by changes in gratitude bias and patients' and service users' sense of engagement and involvement with the system.

6.51 There appears to be some systematic variation in experience for patients in different ethnic groups. Overall, patients from black and minority ethnic groups were less likely to report a positive experience on many of the underlying survey questions. However, these patterns did not appear to change over time[2].

(b) Indicator 4b: Current Practice Projections

6.52 A flat projection for the period 2012/13 to 2017/18 is predicted. This projection is based on the 2011/12 score, that is, 75.6 out of 100 for each year, as overall scores at national level show a flat trend and the policy initiatives currently in place might not have an immediate impact on national levels of reported patient experience.

6.53 Scores should not fall below this value in a statistically significant way, that is, not below 75.5. Whether scores for different years are significantly different will be tested using a t-test and 5% significance threshold.

(c) Indicator 4b: Scope for Improvement

6.54 The factors considered to define the scope for improvement are described at the beginning of section (2).

6.55 The overall score in 2011/12 indicates a level of experience that patients might rate as good, on average, so there remains some room for improvement, both in addressing those cases where care falls below this level, but also in seeking improvement so that average levels move towards very good or excellent.

6.56 Several policy initiatives/national frameworks aim to drive up the quality of patient experience:

- The Outcomes Framework.
- Two NICE Quality Standards have been published on patient experience – one for adult NHS services and one for adult mental health. Both standards provide evidence-based advice on what constitutes good patient experience.
- A patient experience framework has been published covering 8 domains of patient experience. Evidence shows these domains are the areas that matter most to patients, and the framework is designed to help the NHS to focus their efforts/resources in the areas that will really make a difference to patients.
- Quality Accounts – organisations may wish to include progress against this indicator in their QAs to demonstrate to the public their progress and future plans.

- NHS Constitution – one of the 7 key principles guiding the NHS includes focusing on patient experience in the planning and delivery of services.
- Recent research from Kings Fund/Kings College London established a core body of evidence about what matters to patients, and sets out a way forward for improving patient experience in the NHS. This research is supported by Transforming Patient Experience: The Online Guide – a resource created by the NHS Institute to help organisations to improve patient experience[5].

6.57 However, the indicator is expected to be mostly sensitive to local changes in inpatient experience, as specific central initiatives are not usually designed to drive large substantive improvements across the board, for all Trusts, for all aspects of care. For example, the Operating Framework for the NHS in England 2012/13[4] is clear about the need to measure and act upon patient feedback generally, and other national frameworks and policies, such as the Commissioning for Quality and Innovation payment framework[6], and the NHS Patient Experience Framework[7], are designed to help the NHS drive up the quality of services they deliver. It is too early to assess the long-term impact of these initiatives on patient experience scores.

6.58 Therefore, the main impact of any central initiative is expected to be on those areas that show particularly weak performance, for example, the handful of Trusts with patients reporting poor overall experience[8]or specific survey questions that show consistent weakness. In these areas, we might expect that a small number of areas will show large improvements, whilst the bulk of areas will be 'flat'. A few high performing ones might show slight falls based on 'regression to the mean'. (Natural variation in measurements might look like change in patient experience, mainly when unusually large or small measurements are followed by measurements that are closer to the underlying mean – this statistical phenomenon is called ‘regression to the mean’.)

6.59 In order to calculate a scope for improvement at domain level, we are assuming that it may be possible to raise performance for the lowest-performing 25% of trusts above the lowest quartile value – 73.6 in 2011/12.

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4.1 – Patient experience of outpatient services

Outcome sought	Improving patients' experiences of NHS outpatient care.
Updated definition	The indicator is a composite taking values between 0-100, calculated as the average of five survey questions that measure elements of experience across the three stages of the care pathway: pre-visit; during the visit to the Outpatients department; and the transition/post-visit period. Scores are standardised by age and gender.

(a) Indicator 4.1: Recent Trends and Explanations

6.60 Patient experience for outpatient services has had a statistically significant increase from 78.6 out of 100 in 2009 to 79.5 in 2011, and both scores indicate a level of experience of care that patients might rate as good, on average – see table 4.1a.

Table 4.1a Adult outpatient survey - National scores (scores out of 100)

	2009	2011
Score	78.6	79.5

Source: NHS IC Indicator Portal

Note: The 2011 survey was conducted between June and October 2011 and the 2009 survey was conducted between July and October 2009. There are no data for 2010 as the survey has been conducted on an ad hoc rolling basis.

Breakdown by question

6.61 The 2009 and 2011 results from the Care Quality Commission's survey of patient experience of outpatient services showed that for the five questions composing the indicator, patient experience improved significantly for two questions between the two survey years: being informed about what would happen in the appointment, and feeling involved in the care decisions. Table 4.1b. shows the percentage of responses for the categories assigned a score of 100 in these questions.

Table 4.1b. Scores by question (scores out of 100)

Question	2009	2011	Statistically significant change 2009 to 2011
Pre visit			
7. Before your appointment, did you know what would happen to you during the appointment?	61.3	65.2	Yes, significant increase
During visit			
32. Did doctors and/or other staff talk in front of you as if you weren't there?	92.3	92.1	Yes, significant decrease
35. Sometimes in a hospital or clinic, a member of staff will say one thing and another will say something quite different. Did this happen to you?	91.8	91.7	No
36. Were you involved as much as you wanted to be in decisions about your care and treatment?	82.3	83.3	Yes, significant increase
Post visit/transition			
48. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?	65.6	65.4	No

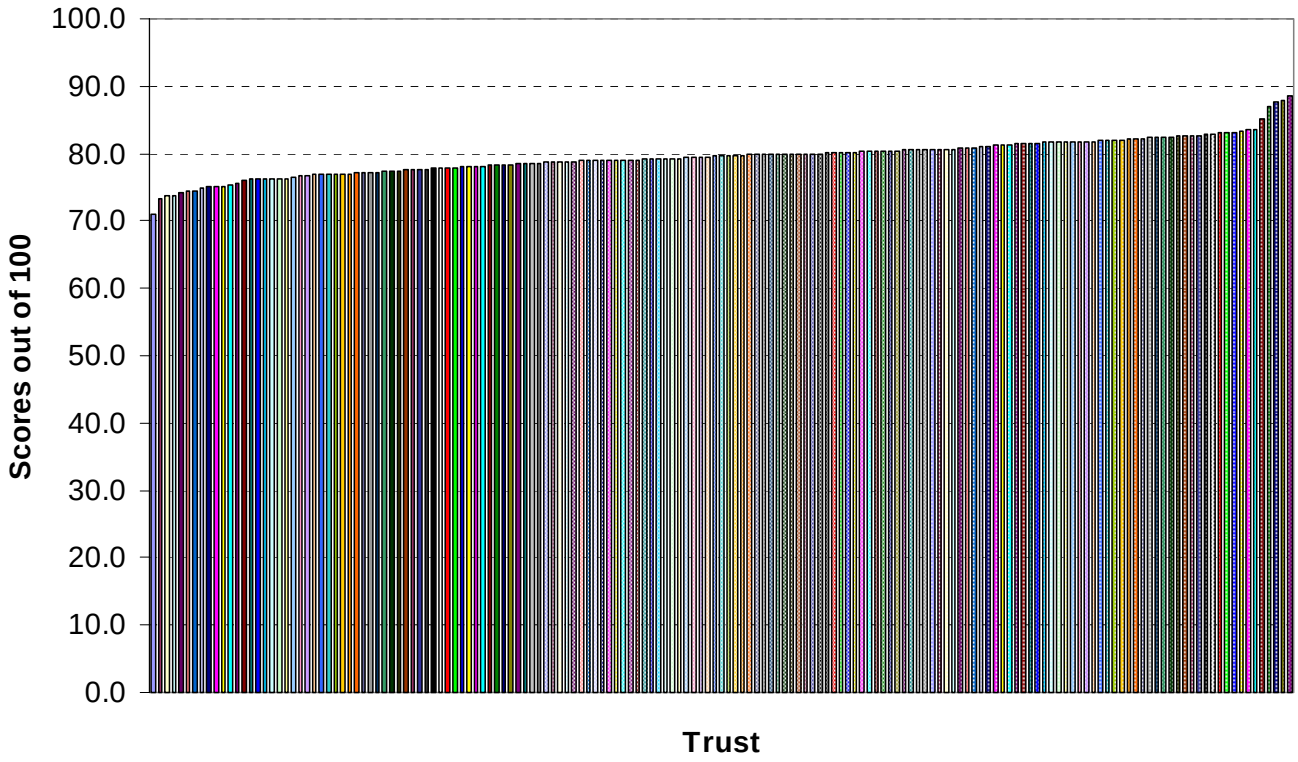
Sources: DH

Note: Individual questions are scored according to a pre-defined scoring regime that awards scores between 0-100. All question's responses are converted to scores using this scoring scheme. The mean of the scores for each question is calculated for each trust to give the trust indicator score. The mean of the trust scores is calculated to give the national indicator score, which will also take values between 0-100.

Breakdown by trust

6.62 Across trusts, 2011 scores range from 71.0 to 88.5, with a lower quartile of 77.8, median of 79.6, upper quartile of 81.25 – see Figure 4.1a.

Figure 4.1a Overall scores for each trust, from low to high score



Source: NHS IC Indicator Portal

Other breakdowns

6.63 Demographic and regional breakdowns are not available.

International position

6.64 Not available

Possible sources of bias

6.65 Please consult indicator '4b Patient experience of hospital care'.

(b) Indicator 4.1: Current Practice Projections

6.66 A flat projection for the period 2012/13 to 2017/18 is predicted. This prediction is based on the 2011 score, that is, 79.5 out of 100 for each year, as overall scores at national level show a flat trend and the policy initiatives currently in place might not have an immediate impact on national levels of reported patient experience for outpatient services.

6.67 Scores should not fall below this value in a statistically significant way, that is, not below 79.1. Whether scores for different years are significantly different will be tested using a t-test and 5% significance threshold.

(c) Indicator 4.1: Scope for Improvement

6.68 The factors considered to define the scope for improvement are described at the beginning of section (2).

6.69 In order to calculate a scope for improvement at domain level, we are assuming that it may be possible to raise the performance of the lowest-performing 25% of trusts above the lower quartile value – 77.8 in 2011.

References

1. Care Quality Commission. Outpatient survey 2011. Accessed: http://www.cqc.org.uk/public/reports-surveys-and-reviews/surveys/outpatient-survey-2011.

2. Department of Health (14 February 2012). Patient Experience Overall Measure – update to include 2011 Outpatient Survey results. Accessed: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsStatistics/DH_132388

3. Department of Health (24 November 2011). The Operating Framework for the NHS in England 2012-13. Accessed: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_131360

4.2 – Responsiveness to in-patients' personal needs

Outcome sought	Improved responsiveness to patients' personal needs.
Indicator definition	The indicator is a composite, calculated as the average of 5 survey questions. Each question describes a different element of the overarching theme, "responsiveness to patients' personal needs". Scores are standardised by age and gender.

(a) Indicator 4.2: Recent Trends and Explanations

6.70 Responsiveness to adult in-patient needs has showed virtually no change from 2010 to 2011, 67.3 and 67.4 respectively. Both scores indicate a level that patients might rate as good, on average – see table 4.2a. The scores do not translate directly into descriptive words or ratings, but in general, if patients reported all aspects of their care as 'good', we would expect a score of about 60. If they reported all aspects as 'very good' we would expect a score of about 80.

6.71 The score was between 66.0 out of 100 and 68.2 out of 100 each year from 2003 to 2011 and it does not show consistent improvement or deterioration over the period – see table 4.2a.

Table 4.2a Responsiveness to adult in-patients' personal needs - national scores (scores out of 100) from Commissioning for Quality and Innovation (CQUIN)

	2003	(…)	2005	2006	2007	2008	2009	2010	2011
National Score	67.4		68.2	67	66	67.1	66.7	67.3	67.4

Sources: NHS IC Indicator Portal for data for 2003 to 2010, DH for data for 2011 (and also for previous years) 1.
Note: There was no data collection for 2004/05.

Breakdown by question

6.72 The national score for the individual questions does not show consistent improvement or deterioration over the period – see table 4.2b and Figure4.1a. Overall, scores range from around 46 out of 100 to 82 out of 100[2]. Whilst scores for different areas cannot be compared directly, this is an indication that patients give high scores for privacy when discussing their condition or treatment and low scores for questions on having someone to talk to about worries and fears, and on information on medication side effects.

6.73 Individual patient responses to each question are given a score out of 100, using a pre-defined scoring scheme. The most positive answer always receives a score of 100, and the most negative gets a score of 0. Intermediate responses (for example those saying that a patient 'sometimes' experienced a particular issue) are given scores between 0 and 100, again on a pre-defined scale.

6.74 There are two reasons why scores for different questions cannot be compared directly:

- Scores are not comparable across questions. There is no reason to suppose that a score of 50 on one question is directly equivalent to a score of 50 on another question.
- The relative value judgement applied to each question is not necessarily equivalent for patients. For example, being treated with respect is not necessarily equivalent to feeling that doctors seemed to work well together.

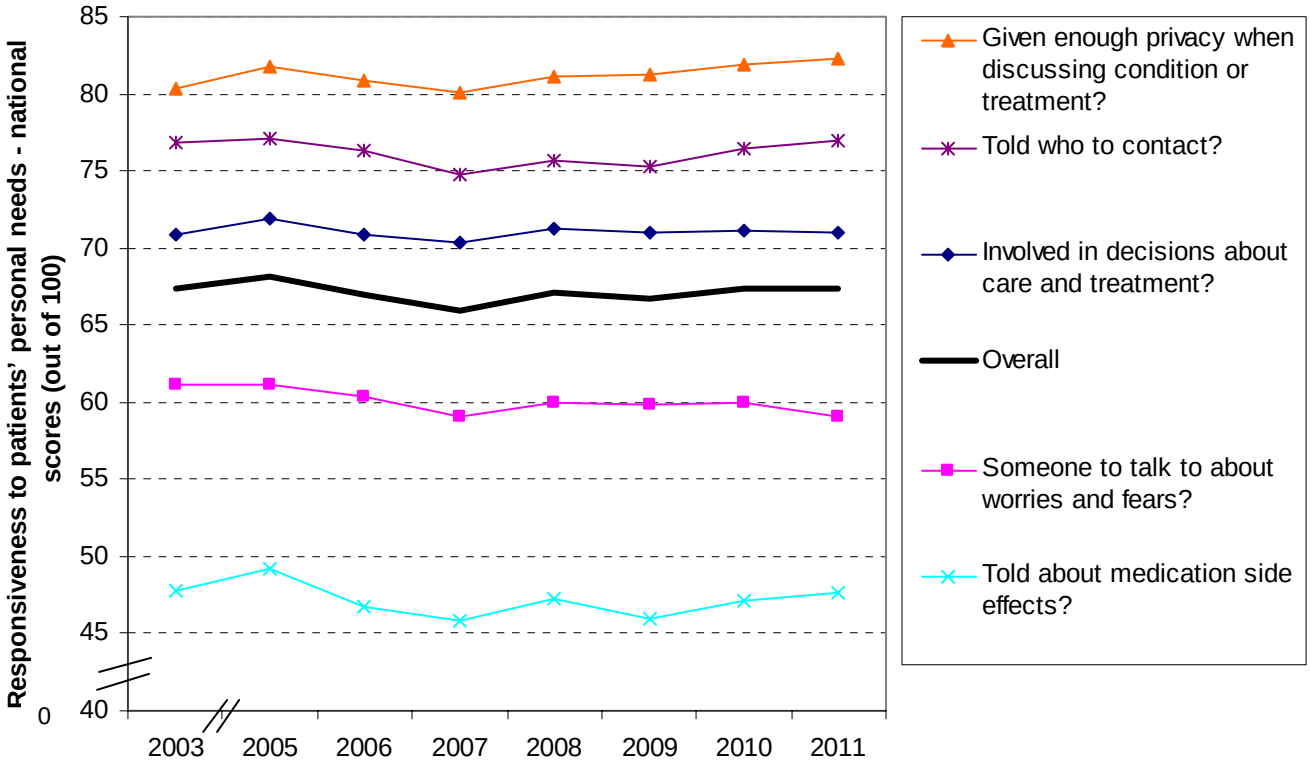
6.75 This does not call into question the results. This is a valid and typical approach to scoring social surveys, but the implication is that scores from one question should not be directly compared with scores from another.

Table 4.2b Responsiveness to patients' personal needs by question - national scores (scores out of 100)

Question	2003	(…)	2005	2006	2007	2008	2009	2010	2011
Were you as involved as you wanted to be in decisions about your care and treatment?	70.9		71.9	70.9	70.4	71.3	71.0	71.1	71.0
Did you find someone to talk to about worries and fears?	61.2		61.2	60.4	59.1	60.0	59.8	60.0	59.1
Were you given enough privacy when discussing your condition or treatment?	80.3		81.7	80.8	80.1	81.1	81.2	81.8	82.3
Were you told about medication side effects to watch out for when you went home?	47.8		49.2	46.7	45.8	47.3	46.0	47.1	47.6
Were you told who to contact if you were worried about your condition after you left hospital?	76.8		77.1	76.3	74.7	75.6	75.3	76.5	77.0

Source: DH
Note: There was no data collection for 2004/05

Figure 4.2a. Responsiveness to patients' personal needs by question - national scores (scores out of 100)



Source: DH

Other breakdowns

6.76 Demographic breakdowns are not available. Scores for individual questions at trust level can be found in the CQUIN tool published by the Department of Health[1].

International position

6.77 Not available.

Possible sources of bias

6.78 Please consult indicator '4b Patient experience of hospital care'.

(b) Indicator 4.2: Current Practice Projections

6.79 A flat projection for the period 2012/13 to 2017/18 is predicted. This prediction is based on the 2011 score, that is, 67.4 out of 100 for each year, as overall scores at national level show a flat trend and the policy initiatives currently in place might not have an immediate impact on national levels of reported patient experience. Scores should not fall below this value in a statistically significant way. Whether scores for different years are significantly different will be tested using a t-test and 5% significance threshold.

(c) Indicator 4.2: Scope for Improvement

6.80 Please see section Domain 4 (3) (a)

References

1. Department of Health. National Patient Experience CQUIN Indicator Tool Accessed: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_133687.xls

2. The Care Quality Commission publishes the national results for each question response category and historical comparisons at http://www.cqc.org.uk/sites/default/files/media/documents/ip11_national_tables_final.pdf

3. Department of Health (24 November 2011). The Operating Framework for the NHS in England 2012-13. Accessed: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_131360

4.3 – Patient experience of A&E services

Outcome sought	Improvement in patients' experiences of Accident and Emergency (A&E) departments.
Updated definition	The indicator is a composite measure taking values between 0-100, calculated as the average score of 5 survey questions that measure a different element of the overarching theme: Improving people's experiences of Accident and Emergency services. The questionnaire is for patients aged 16 and over. Scores are standardised by age and gender.

(a) Indicator 4.3: Recent Trends and Explanations

6.81 The value for 2008 was 80.0 (on a scale of 0-100), which indicates good patient experience. The survey for this indicator is not run every year and we do not yet have a time series on which to assess change. The next survey will be conducted in 2012/13, with expected publication date on January 2013.

Breakdown by question

6.82 The score is based on five questions covering communications with doctors and nurses, involvement in decisions about treatment, pain control and being treated with respect and dignity. These questions were chosen to be complementary to the other measures used to assess A&E quality and performance (which tend to focus on time and waiting), rather than duplicate them, and to be a marker for Trusts to use to investigate their performance further.

6.83 The Care Quality Commission reports results for the questions that compose the indicators. The questions on communication with doctors and nurses, confidence in doctors and nurses and being treated with respect and dignity, show a percentage of respondents reporting good experience (around 60-80%). For questions on involvement in decisions about treatment and pain control, around 60% of the respondents report a good experience. When emergency care is being offered, it is sometimes difficult to control pain to the patient's satisfaction if the injury is severe. In addition, it may not be possible to involve the patients in all decisions about their care if there is an urgent clinical need to make a decision, or if the patient is not conscious or not fully aware of the situation. Services should be able to interrogate further, particularly if they score lower than other providers do. Table 4.3a. shows the percentage of responses for the response categories assigned a score of 100 in these questions.

Table 4.3a. Percentage of responses by question to selected response categories

Question	Response category	2003	2004	2008	Statistically significant change 2004 to 2008
Q12: While you were in the Emergency department, did a doctor or nurse explain your treatment in a way you could understand?	Yes, completely	65%	67%	67%	No
Q15: Did you have confidence and trust in the doctors and nurses examining and treating you?	Yes, definitely	73%	73%	73%	No
Q21: Were you involved as much as you wanted to be in decisions about your care and treatment?	Yes, definitely	63%	64%	62%	Significant decrease
Q27: Do you think the hospital staff did everything they could to help control your pain?	Yes, definitely	55%	56%	59%	Significant increase
Q39: Overall, did you feel you were treated with respect and dignity while you were in the Emergency department?	Yes, all of the time"	77%	79%	78%	Significant decrease

Source: Care Quality Commission.

Note: Please note that these percentages are not the scores for the indicator. Individual questions are scored according to a pre-defined scoring regime that awards scores between 0-100. All questions responses are converted to scores using this scoring scheme. The mean of the scores for each question is calculated for each trust to give the trust indicator score. The mean of the trust scores is calculated to give the national indicator score, which will also take values between 0-100.

Other breakdowns

6.84 Demographic and regional breakdowns are not available at this time.

International position

6.85 Not available.

Possible sources of bias

6.86 Please consult indicator '4b Patient experience of hospital care'.

(b) Indicator 4.3: Current Practice Projections

6.87 A flat projection for the period 2011/12 to 2017/18 is based on the 2008 score of 80.0 out of 100 for each year, as scores at national level generally show a flat trend. This indicates a good level of patient experience.

6.88 Scores should not fall below this value in a statistically significant way. Whether scores for different years are significantly different will be tested using a t-test and 5% significance threshold

6.89 The Operating Framework for the NHS in England 2011/13 reinstated the four-hour A&E waiting time standard at 95% threshold, as part of set of eight clinical quality indicators. The remaining seven clinical quality indicators are for local determination, and are:

- Unplanned re-attendance rate
- Left department before being seen for treatment rate
- Time to initial assessment
- Time to treatment
- Ambulatory care
- Service experience
- Consultant sign-off

6.90 The service experience indicator in particular focuses on the experience of patients using A&E services and their carers, what the results were, and what has been done to improve services in light of the results. The results of such information gathering should be discussed locally and explored so that key areas for service improvement can be determined. However, the impact on reported patient experience at national level might not be immediately visible.

(c) Indicator 4.3: Scope for Improvement

6.91 The factors considered to define the scope for improvement are described at the beginning of section (2).

6.92 Transformation of urgent and emergency care services and the NHS 111 service as outlined as evidence for the scope for improvement for indicator 4a could also likely to lead to improvements in this outcome within current resources. In addition, effective case management can also improve patient experience and health outcomes.

References

1. Care Quality Commission (March 2012). NHS Patient and staff experience survey programme: outline programme 2011/12 and 2012/13. Accessed: http://www.cqc.org.uk/public/reports-surveys-and-reviews/surveys

2. Care Quality Commission. Historical Comparison Tables: Emergency Department Survey Results 2008. Accessed: http://www.nhssurveys.org/survey/1036

4.4 – Access to i. GP Services ii. NHS Dental Services

Outcome sought	Improvement in patients' access to GP services, and access to NHS Dental services.
Indicator definition	Percentage of the GP Patient Survey respondents reporting "Very Good" or "Fairly Good" experience of making an appointment for GP services and percentage reporting being successful in getting an NHS dental appointment. The survey is for adults aged 18 and over.

(a) Indicator 4.4: Recent Trends and Explanations

6.93 There is currently no trend to report. Indicator 4.i will be based on aggregated data from two collections each year from 2011/12. The first wave for 2011/12 covers July to September 2011. Data for wave 2 will be published on 14 June 2012, and the first release of the indicator should be published soon after that.

6.94 Indicator 4.ii is different, since dental figures are published separately as wave one and then wave two instead of being aggregated. Therefore, for this indicator we already have the first data point of the time series.

6.95 The figures below show the wave-one data currently available for each part of the indicator – see Tables 4.4a and 4.4.b.

Table 4.4.a Percentage of respondents reporting good experience of making an appointment for GP services (weighted)

	Question	Good
Access to GP services	Q.18 Overall, how would you describe your experience of making an appointment?	79%

Source: GP Patient Survey[1]

Table 4.4.b Percentage of respondents reporting being successful in getting an NHS dental appointment (weighted)[2]

	Question	Yes
Access to NHS dental services	Q.44 Were you successful in getting an NHS dental appointment?	95%

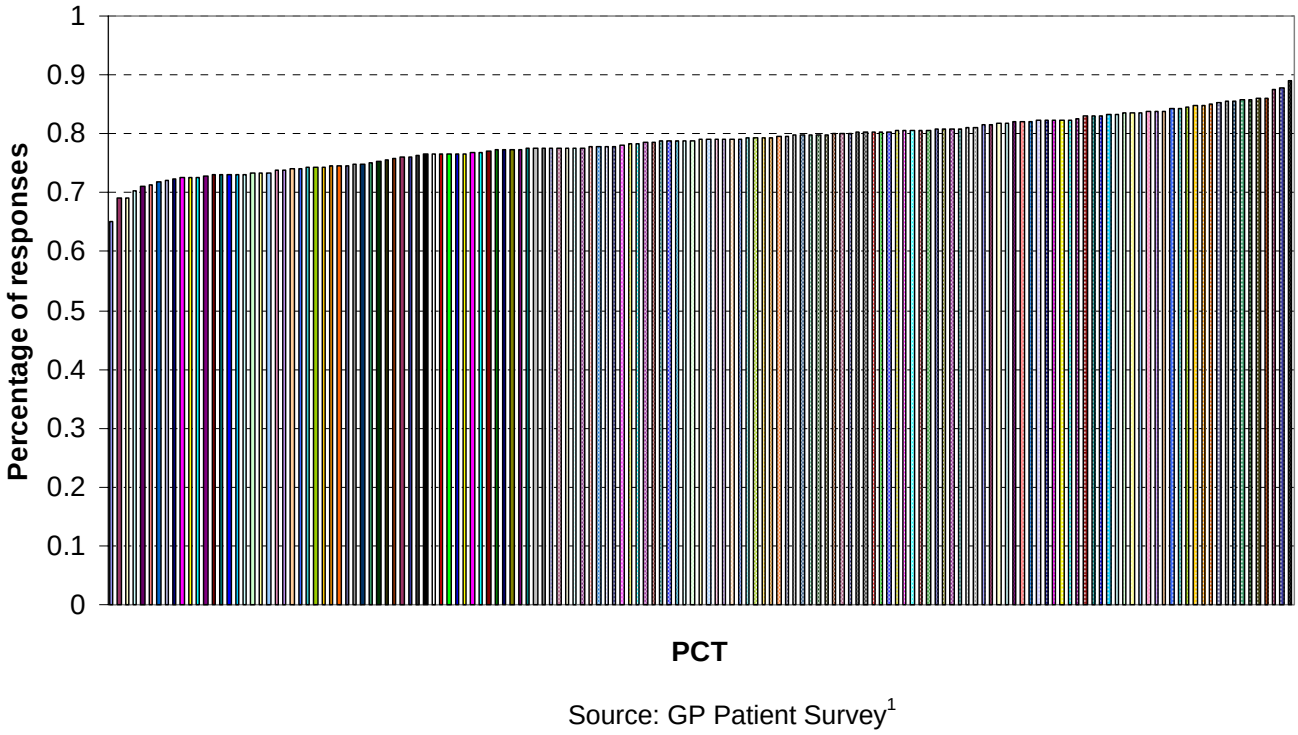
Source: DH

[2] These respondents are those who have tried to get an NHS dental appointment in the last two years and were selected to the GP Patient Survey sample. Therefore, these respondents should not be seen as a representative sample of NHS Dental patients.

Breakdown by Primary Care Trust

6.96 Across Primary Care Trusts (PCTs), the percentage of respondents reporting a good experience when making an appointment with their GP surgery ranges from 65% to 89%, with the lower quartile of 76%, median of 79% and the upper quartile score of 82% – see figure 4a.a.

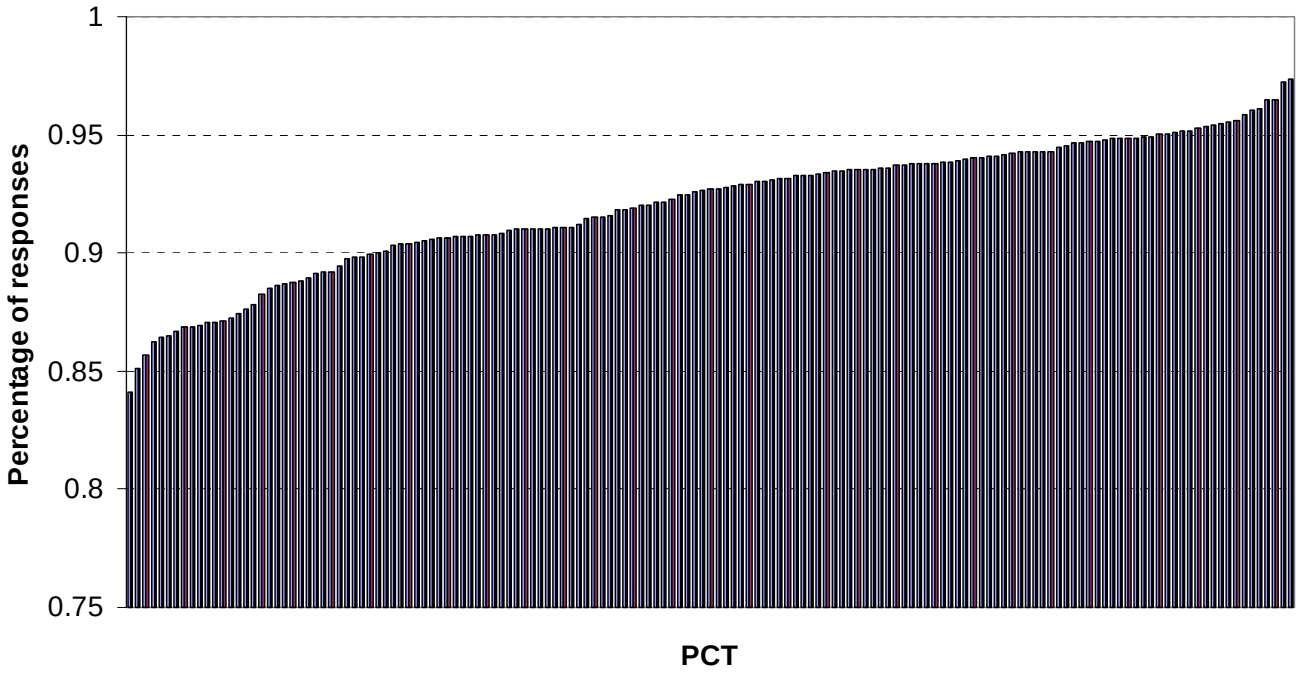
Figure 4.4.a Percentage of respondents reporting good experience when making a GP appointment by PCT, from low to high score



Source: GP Patient Survey[1]

6.97 Across Primary Care Trusts (PCTs), the percentage of respondents reporting being successful making a NHS Dental appointment ranges from 84% to 97%, with the lower quartile of 90%, median of 93% and the upper quartile score of 94% – see figure 4.4.b.

Figure 4.4.b Percentage of respondents reporting being successful making a NHS Dental appointment by PCT, from low to high score



Source: GP Patient Survey[1]

(b) Indicator 4.4: Current Practice Projections

6.98 Since these are new indicators, they will at first be projected forward as a flat projection. This provisional forecast will need to be reviewed as more data becomes available and the trend of the indicator can be understood.

6.99 For 4.4.i this will be done once the full data point for 2012 becomes available. For 4.4.ii, a flat projection for the period 2012/13 to 2017/18 is based on the Q2 2011/12 score, that is, 92 out of 100 for each year.

(c) Indicator 4.4: Scope for Improvement

6.100 Please see template 4a for a discussion of the scope for improvement of patient experience of Primary Care services. More work is needed to ascertain what the scope for improvement is for this indicator.

References

1. GP Patient Survey, Latest weighted results. Accessed: http://www.gp-patient.co.uk/results/

2. Department of Health (24 November 2011). The Operating Framework for the NHS in England 2012-13. Accessed: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_131360

4.5 – Women's experience of maternity services

Outcome sought	Improving women's experience of maternity services.
Updated definition	This indicator is a composite score using six questions in the 2010 Care Quality Commission survey of women's experience of maternity services focusing on the whole maternity care pathway (antenatal, intrapartum and postnatal). It takes values between 0-100. Responses are standardised by maternal age and parity (number of previous births).

(a) Indicator 4.5: Recent Trends and Explanations

6.101 The baseline value for 2010 was 77 out of 100 based on questions covering the whole maternity care pathway (antenatal, labour and delivery, postnatal), which indicates a level of experience that patients might rate as good, on average. This survey is not run every year and we do not yet have a time series on which to assess change.

6.102 Results showed that nationally more than 90% of women surveyed reported being involved enough in decisions about the antenatal and intrapartum care received and being treated with kindness and understanding after the birth, more than 85% reported being given enough information and support. 78% of the respondents said they were not left alone by midwives or doctors at a time during labour/birth when it worried them – see table 4.5a.

Table 4.5a. Percentage responding positively to questions B6, B24, C16, D4, E5 and C14 (see note to the table)

Question	2010
Antenatal	
B6. Did you get enough information from a midwife or doctor to help you decide where to have your baby?	88%
B24. Thinking about your antenatal care, were you involved enough in decisions about your care?	96%
Intrapartum (labour and delivery)	
C14. Were you (and/or your partner or a companion) left alone by midwives or doctors at a time when it worried you?	78%
C16. Thinking about your care during labour and birth, were you involved enough in decisions about your care?	94%
Postnatal	
D4. Thinking about the care you received in hospital after the birth of your baby, were you treated with kindness and understanding?	94%
E5. Did you feel that midwives and other carers gave you active support and encouragement?	86%

Source: Care Quality Commission[1]

Note: Percentage responding "Yes, definitely"/ "Yes, always" or "Yes, to some extent"/ "Yes, sometimes"/ "Yes, generally"; or "No" to question C14. Please note that these are not the scores for the indicator.

Other breakdowns

6.103 Demographic and regional breakdowns are not available.

International position

6.104 Not available.

Possible sources of bias

6.105 See indicator 4b.

(b) Indicator 4.5: Current Practice Projections

6.106 A flat projection for the period 2011/12 to 2017/18 is based on the 2010 baseline score of 77 out of 100 for each year, which indicates a good level of patient experience. Scores should not fall below this value in a statistically significant way. Whether scores for different years are significantly different will be tested using a t-test and 5% significance threshold.

6.107 The ratio between midwives and the birth rate is now similar to the rate 10 years ago. In the last 10 years, the birth rate and midwifery numbers have both increased by a similar level of around 17%. Currently there are approximately 5,000 midwifery students in training, who will qualify over the next 3 years. The numbers of Maternity Support Workers have also increased over this period. However, the change in the complexity of the case mix with older women, more obese women and women with co-morbidities is a newer challenge.

(c) Indicator 4.5: Scope for Improvement

6.108 The factors considered to define the scope for improvement are described at the beginning of section (2).

6.109 The Operating Framework for the NHS in England 2012/13 makes clear the importance that the Government attached to choice and continuity in all aspects of maternity care from antenatal care through to support at home. The investment in a record 5,000 midwives currently in training, means that maternity services will be able to ensure that women have one named midwife who will oversee their care during pregnancy and after they have had their baby, and one-to-one midwife care during labour and birth. This investment also means that parents-to-be will get the best choice about where and how they give birth. More joined up working by maternity providers can help women to make safe, informed choices from a full range of services, which are delivered within an integrated, flexible service.

6.110 The Birthplace in England study[2]provides clinicians and service providers with evidence to improve the information and advice they give to women about choosing a place of birth. The study provides evidence about the expected outcomes for women and their babies at ‘low-risk’ of complications at the start of care in labour for births planned at home, in a midwifery facility or in a hospital unit with obstetric services. Commissioners and providers are also able to use the study to inform their planning of maternity services and clinical guidelines.

6.111 Maternity services work within local networks which bring together all the services that a woman needs throughout pregnancy, birth and afterwards. Women are able to access the full range of maternity services through their local service provider.

6.112 Health professionals have an important role in ensuring that parents-to-be and new parents have the advice and information they need, and are prepared for pregnancy and to care for their baby. On 18 May the Government launched the NHS Information Service for Parents. Parents-to-be and new parents can sign up to receive regular free emails, videos and SMS messages offering high quality NHS advice and information related to the stage of pregnancy and age and development of their child. The NHS Information Service for Parents is a key resource for health professionals to help enable parents to access the information they need when they need it.

References

1. Care Quality Commission (December 2010), Historical Comparisons Tables: Maternity Survey Results 2010. Accessed: http://www.nhssurveys.org/Filestore//documents/MAT10_Historical_comparisons_tables.pdf (main website: http://www.nhssurveys.org/results)

2. University of Oxford/ National Perinatal Epidemiology Unit, Birthplace in England Research Programme. Accessed: https://www.npeu.ox.ac.uk/birthplace

4.6 – Survey of bereaved carers

Outcome sought	Improving the experience of care for people at the end of their lives.
Updated definition	The definition for this indicator is being finalised. It will be a national indicator to measure the quality of care experienced by adults caring for those in the final three months of life. It is derived from a new national survey of people who have been bereaved, which has already been piloted. The survey is for people aged 18 and over.

(a) Indicator 4.6: Recent Trends and Explanations

6.113 The indicator definition is being finalised and data will be published during 2012.

(b) Indicator 4.6: Current Practice Projections

6.114 To be decided.

(c) Indicator 4.6: Scope for Improvement

6.115 The factors considered to define the scope for improvement are described at the beginning of section (2).

6.116 Several current and planned policy initiatives are likely to lead to improvements in this outcome within current resources. The End of Life Care (EoLC) is a workstream in the Quality, Innovation, Productivity and Prevention (QIPP) programme, which is focussing particularly in the early part of the EoLC pathway – identifying people who are approaching the end of life and planning for their care – and the societal aspects of breaking the taboo on discussing death and dying. Headline work within the workstream is:

- Dying Matters – a national coalition (16,000 members) addressing the public and professionals about ways to approach the eolc conversation and the benefits it offers
- Find Your 1% - a campaign encouraging GPs to find the (approx) 1% of patients on their lists who are likely to be in their final year of life, and then to discuss and plan for their care and preferences
- Electronic Palliative Care Coordination Systems (EPaCCS) rollout – enabling electronic communication of key information (MDS mandated through the ISB) to all of an individual's care providers

6.117 The Key Performance Indicators (KPIs) to improve are a) proportion of deaths in usual place of residence and b) reduction on numbers of deaths in hospital after a final stay of 8+ days (to be piloted) will have agreed national and local trajectories to meet a stretch ambition.

6.118 There are also a range of activities underway to support implementation of the End of Life Care Strategy which will impact on outcomes within current resources. Within the Department of Health, there is a Ministerial commitment, set out in Liberating the NHS: Greater Choice and Control, to introduce a right to choice for people to choose to die at home, and have the support necessary to do so. The service development required to meet this right will be delivered through ongoing implementation of the Strategy, and work undertaken through existing initiatives such as the QIPP programme.

6.119 The National End of Life Care Programme, which is tasked with supporting Strategy implementation, has a number of activities in train:

- Ongoing support for, and encouraging take-up of, comprehensive e-learning for end of life care through E-Learning for Health, which is free to access for all health and social care staff
- Support for commissioners of end of life care services, through: developing intelligence about end of life care service provision and need through the National End of Life Care Intelligence Network; and communicating commissioning guidance developed by NICE to support the NICE Quality Standard for end of life care for adults
- Supporting and facilitating an acute hospitals workstream, which is identifying the best ways to improve care in an acute setting

6.120 Aside from these initiatives there is evidence there could be further scope for improving this outcome at zero net cost by reducing regional variation and/or rolling out best practice.

6.121 Comparisons between different areas do show scope for improving NHS performance, which is reflected in the current development of stretch targets for Key Performance Indicators.

6.122 One of the key roles of the National End of Life Care Programme is to identify and share best practice, which they do through a number of channels:

- Supporting and working with colleagues in the NHS, social care and the voluntary sector (such as local end of life care facilitators and social care champions for end of life care)
- Facilitating and supporting the development of end of life care service frameworks/disease specific frameworks eg for social care, hospitals, prisons, renal disease etc
- Supporting the roll out of tools to improve care delivery eg the Liverpool Care Pathway, the Amber Care Bundle, and others.

6.123 There is also potential scope for improvement by redeployment of resources between conditions, service lines and health economies.

6.124 Most people when asked express a wish to die at home, though most die in hospital. A key focus of the work on end of life care is to support delivery of care at home and in the community, in line with people's preferences. Key to this is the shift in resources from the hospital to the community sector, with investment in the right areas, such as 24/7 nursing services.

6.125 As part of its work on Palliative Care Funding, the Department of Health plans to introduce a new tariff for palliative care in 2015, which will support the effective allocation of resources.

6.126 A NICE Commissioning Benchmarking tool has also been developed which allows commissioners to assess changes to cost profiles arising from changing service configurations.

4.7 – Patient experience of community mental health services

Outcome sought	Improving the experience of adult (18 years and above) mental health patients.
Updated definition	The indicator is a composite, calculated as the average of 4 survey questions from the community mental health survey completed by a sample of patients aged 16 or over who received care or treatment for a mental health condition, including services provided under the Care Programme Approach (CPA). Patients seen only once for an assessment, current inpatients and anyone primarily in receipt of learning disability, drug and alcohol or forensic services were not eligible to take part in the survey. The questions relate to patients' experience in contact with a health and social care walker. The questions are:

(a) Indicator 4.7: Recent Trends and Explanations

6.127 The value for 2010 was 87.2 out of 100 and in 2011 this fell slightly to 86.8, which indicates a level of experience that patients might rate as good, on average.

6.128 The indicator is an average of the following four survey questions:

Thinking about the last time you saw this NHS health worker or social care worker for your mental health condition…

- …Did this person listen carefully to you?
- …Did this person take your views into account?
- …Did you have trust and confidence in this person?
- …Did this person treat you with respect and dignity?

Table 4.7.a Patient experience of community mental health services

Year	4.7 Patient experience of community mental health services
2010	87.2
2011	86.8

Source: NHS Information Centre

Other breakdowns

6.129 Demographic and regional breakdowns are not available at this time.

International position

6.130 Not available.

Possible sources of bias

6.131 Please consult indicator '4b Patient experience of hospital care'.

(b) Indicator 4.7: Current Practice Projections

6.132 A flat projection for the period 2011/12 to 2017/18 is based on the average of the scores for 2010 and 2011, that is, 87 out of 100 for each year, which indicates a good level of patient experience. The low projection interval has been calculated by subtracting the standard deviation of the series from the average score. Scores should not fall below this value in a statistically significant way.

Table 4.7.b Patient experience of community mental health services, actual and projection

Year	4.7 Patient experience of community mental health services
2010	87.2
2011	86.8
2012	87.0
2013	87.0
2014	87.0
2015	87.0
2016	87.0
2017	87.0

Source: NHS Information Centre

(c) Indicator 4.7: Scope for Improvement

6.133 The factors considered to define the scope for improvement are described at the beginning of section (2).

6.134 There could be potential scope for improvement in this indicator by redeployment of resources between conditions, service lines and health economies. Potentially further deployment of resources towards community services – away from some inpatient services. An example of this is the current reconfiguration of the offender personality disorder service, where reinvestment of funding from in-patient services to community services will provide services for increased numbers of people and also provide support to stay in the community rather than re-offend or be readmitted in crisis.

4.8 – Children and young people's experience of healthcare

Outcome sought	Improving children and young people's experience of healthcare.
Updated definition	This indicator will be constructed from questions (to be decided) from a Children's Patient Experience Questionnaire.

(a) Indicator 4.8: Recent Trends and Explanations

6.135 The indicator is under development.

(b) Indicator 4.8: Current Practice Projections

6.136 To be decided.

(c) Indicator 4.8: Scope for Improvement

6.137 Please consult indicator '4b Patient experience of hospital care'.

6.138 The Children's and Young People's Health Outcomes Strategy is under development and will be considering measures of patient experience, and development of this measure, assessing its fitness for purpose, identifying any additional outcomes needed in this area and outlining the contribution that the different parts of the health system need to make in supporting their delivery. Due to its early stage, it is still not possible to estimate scope for improvement in the outcome measured by this indicator.

(3) Domain 4 Levels of Ambition

6.139 This section considers for Domain 4 as a whole:

(a) Aggregated Scope for Improvement

(b) Levels of Ambition

(c) Implications for Inequality

(3)(a) Domain 4 Aggregated Scope for Improvement

6.140 In this section, initial assessment of the aggregated scope for improvement for Domain 4 is measured in the overall change in average patient experience and is derived from the scope for improvement for individual indicators. It is difficult to quantify the potential for improvement in the average patient experience, notably because of the potential for changes in patient expectations to offset ant improvements. Therefore some indicative analysis based on improving patient experience amongst the poorest performers is presented. This subject to change over the consultation period as more analysis is done to identify possible improvements.

6.141 In order to calculate a scope for improvement at domain level, it may be possible to raise the performance of the lowest-performing 25% of trusts above the lower quartile value. These are small but statistically significant changes. However, this scope for improvement would involve removing unexplained variation in patient experience. While in principle equally good performance should be possible in all regions (assuming that the resource allocation system is fair), there is limited evidence that it is possible to reduce variation at no additional cost. The drivers of variation and barriers to change are not well understood. Therefore, this initial scope for improvement is potentially over or under ambitious and requires further exploration.

6.142 Where analysis has shown what particular aspects of care drive improvement, it may be possible to assess the cost of driving up overall care experience by making changes affecting that aspect. For example, introducing Choose and Book should mitigate the extent that patients are frustrated by uncertainty with respect to appointment times.

6.143 However, other aspects of care experience, involving the relationship established with the patient, are both more important and more difficult to improve. Cross institution variation in performance may be the best indication of potential for improvement in this domain.

Table 4.1 Domain 4 - Average Weighted Patient Experience

	Current practice projection	***Scope for improvement***	***Average patient experience (including scope for improvement)***
2012/13*	78.0	0	78.0
2013/14	78.0	0	78.0
2014/15	78.0	0.1	78.1
2015/16	78.0	0.2	78.2
2016/17	78.0	0.3	78.3
2017/18	78.0	0.4	78.4
2018/19	78.0	0.5	78.5
2019/20	78.0	0.6	78.6
2020/21	78.0	0.6	78.6
2021/22	78.0	0.7	78.7
2022/23	78.0	0.8	78.8

Scope for Improvement and Levels of Ambition Calculation method

6.144 Each indicator (where data are available) is expressed as an average patient experience between 0 and 100. The domain metric is also expressed in this unit. Therefore it is possible to do a weighted average of the scores over the different indicators. The weighting is described below.

6.145 There is variation in the average patient experience scores in different areas of the country, currently data on variation is only available for three indicators. Where there are no variation data available we have assumed a similar improvement is possible

6.146 The percentage point rise in average patient experience is calculated as follows:

- An estimate is made of the lower quartile patient experience score where variation data are available;
- Scope for improvement is based on moving all those NHS trusts in the lower quartile up to the lower quartile score;
- A new average patient experience score is calculated based on this improvement
- These improvements are assumed to be achieved by 2017/18, the end of the projection period, this results in a 0.4 percentage improvement for all three indicators; and
- The equivalent continuing improvement is then projected forward for the next 5 years

Weighting across scope for improvement in different indicators

6.147 Two different options for weighting the different indicators in the domain are presented below. This takes into account the scope for improvement is 0.4 percentage points across the 3 indicators, where data are available.

Table 4.2 – Weighting of patient experience categories

		cost weight (programme budgeting)	***activity * contact time (HES)***
4ai	Patient experience of primary care i GP services	8%	5%
4aii	Patient experience of primary care ii GP Out of Hours services	4%	0%
4aiii	Patient experience of primary care iii NHS Dental Services	3%	0%
4b	Patient experience of hospital care	33%	84%
4.1	Patient experience of outpatient services	18%	1%
4.2	Responsiveness to in-patients' personal needs	10%	0%
4.3	Patient experience of A&E services	4%	3%
4.4i	Access to GP services	8%	0%
4.4ii	Access to NHS dental services	3%	0%
4.5	Women's experience of maternity services	4%	1%
4.6	An indicator to be derived from the survey of bereaved carers	0%	4%
4.7	Patient experience of community mental health services	3%	0%
4.8	An indicator to be derived from a Children's Patient Experience Questionnaire	0%	0%
		100%	

Sensitivities

6.148 The overall scope for improvement is based on extrapolated estimates of the reduction in variation across three indicators, variation across other indicators could be larger or smaller, which would raise or lower the domain level of ambition.

6.149 The improvements in average patient experience score look relatively small, but represent a statistically significant change from year-to-year. In addition this kind of improvement could equate to 60,000 people experiencing better care.

(3)(b) Domain 4 Levels of Ambition

6.150 This section assesses appropriate Levels of Ambition for Domain 4, adding to the scope for improvement of individual indicators the scope for gains in allocative efficiency, conditioned by a realistic assessment of the challenge presented to the NHS to achieve requisite change.

6.151 Development work is also in progress to generate measures of patient experience of the integration of care; levels of ambition should reflect progress in this area both for its own merit and for its contribution to broader measures of experience of care.

6.152 Levels of ambition will be included in the final mandate.

(3)(c) Domain 4 Implications for Inequality

6.153 We will be reviewing this domain to explore relevant considerations for the assessment of inequality.

(4) Domain 4 Considerations for Retrospective Assessment

6.154 This section will draw attention to the factors that should be taken into account when assessing whether overall domain performance by the NHS has met levels of ambition set.