

# Patient Experience

and patient/public involvement in health and care services

Spring 2022



**Patient  
Experience  
Library**

**INSIDE**

**Sling the mesh**

**Ducks in a row**

## Editorial



Our mission to build patient experience more firmly into evidence-based practice has made great strides recently, starting with Health Education England's decision to feature the Patient Experience Library on the new [NHS Knowledge and Library Hub](#). That indicates a recognition that patient experience research can no longer be dismissed as "anecdotal evidence".

We were delighted with the response to our recent Patient Experience and Engagement symposium, co-hosted with Leeds Beckett University. We had expected a niche audience of around 40-50, and were amazed to see 136 people logging in to the online event. Our speakers were excellent, but it was also great to see people using the "chat" to talk to one another directly - making connections and sharing information.

The Whose Shoes podcasts are a goldmine of patient activism and advocacy, so it was an honour to be invited to join in. My discussion with podcast host Gill Phillips covered matters such as the use (and misuse) of language in healthcare, and the need for a professional learning infrastructure for patient experience work. You can [tune in to the podcast here](#).

In this issue of our quarterly magazine, we hear from Kath Sansom about why all this matters. As the founder of the Sling the Mesh campaign, Kath speaks for the thousands of women who spoke out about the harms of pelvic mesh and who, for years, were ignored. She describes continuing government inaction which, she says, "sends an insidious message to women - to put up and shut up".

Our other contributor, Sue Robins, has her own stories about life with cancer, life with a son who has Downs Syndrome, and life as a patient advocate. For her, "health care should be based on relationships, and dare I say, love". As an activist, her message is clear: "We don't have to wait for the CEO to give us permission; we can start now".

As always, we have been picking through some of the latest and best patient experience research, and summarising it through the rest of this magazine. And we're always keen to hear from our readers, so if you know of a standout report that we should be featuring, or if you want to submit a comment piece, get in touch!

*Miles*

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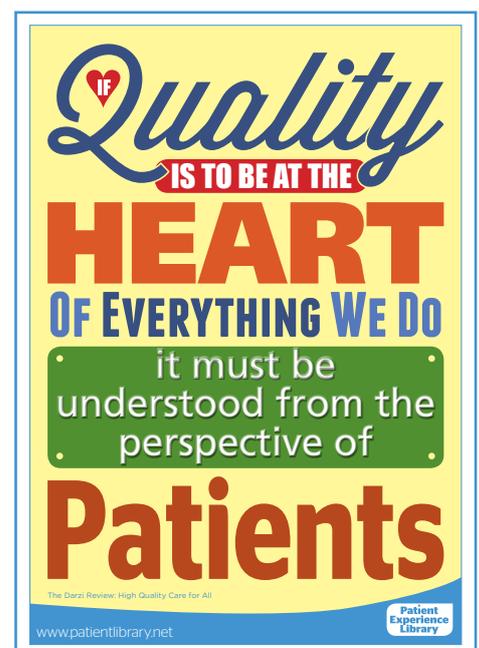
## Services

Feel free to browse the [Patient Experience Library](#) - over 70,000 reports on all aspects of patient experience and engagement. We can build tailor-made local libraries for your Trust or Integrated Care Partnership - drop us a line to find out how.

Check out our [research-based publications](#), and sign up to our weekly newsletter for regular updates. We offer bespoke search and literature reviews like [this](#) and [this](#) - get in touch to find out more.

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**Quality**  
**IS TO BE AT THE**  
**HEART**  
**OF EVERYTHING WE DO**  
it must be  
understood from the  
perspective of  
**Patients**  
The Darzi Review: High Quality Care for All  
[www.patientlibrary.net](http://www.patientlibrary.net) Patient Experience Library

## Comment

Do you have opinions, insights or good practice examples that you'd like to share with our readers? Drop us an e-mail to receive our guide for contributors: [info@patientlibrary.net](mailto:info@patientlibrary.net)

# Sling the Mesh

**Kath Sansom. Founder, Sling The Mesh**  
@MeshCampaign



When Julia Cumberlege published her damning [First Do No Harm](#) report, criticising the healthcare system for three avoidable women's health scandals, the mesh community celebrated that finally our voices had been heard.

With nine key recommendations to ensure a scandal like mesh implants never happens again, we were hopeful of a safer system for the future.

However, nearly two years on, little has changed.

Specialist Mesh Centres set up to support those living in chronic pain are not fit for purpose. Many are run by the same surgeons who denied mesh was a problem, are unable to fully remove all mesh types and have little aftercare - leaving some women with serious issues like embolisms and sepsis.

Waiting lists are up to two years and women report having to jump through hoops before a removal is

even considered - only to be coerced out of the corrective surgery they so desperately want when they finally see the consultant.

There is no formal training and mesh removal styles are hugely different across the UK centres. Nobody is auditing outcomes to see whose method is working best.

It is still not compulsory for doctors to report health treatment complications to the MHRA Yellow Card. The voluntary approach meant a whopping two thirds of mesh complications went into a black hole of missing data, allowing regulators to tell the NHS that mesh was fine - for two decades. There are still no national databases to log long term implant outcomes.

The Government apology after publication of the Cumberlege report was half-baked, and since then Boris Johnson has refused to consider financial redress. This inaction sends an insidious message to women - to put up and shut up.

I set up Sling The Mesh in 2015 (now 9,400 members), after going for "a simple fix" for stress incontinence. Turns out I didn't need surgery at all as 80% of women are cured or improved thanks to physiotherapy. But my consultant said physiotherapy didn't work, so like thousands of women globally, I was put on the surgery list for a permanent plastic mesh sling called a TVT.

I didn't know this sling was for life. I assumed it was like a contraceptive coil

and could be easily taken out if I didn't get on with it. I had no clue a TVT sling was designed to embed permanently into my tissue.

A Sling The Mesh survey shows 9 out of 10 of us were not warned of the risks.

Mesh can take years to cause complications. The plastic can turn brittle acting like an internal knife, slicing into urethras, organs or through vaginal walls. That can take up to 20 years to happen, showing the urgency to track patients for life.

Many of us suffer autoimmune diseases, fibromyalgia and allergies. But we are told there is no evidence to link these to the toxins in the mesh material. Our reply? That is only because studies are only just beginning to emerge on this issue.

On a positive, a Patient Safety Commissioner, the first role of its kind in the world, is due to be appointed this Summer. And Baroness Cumberlege has added amendments to the Health and Social Care Bill around her key recommendations. This includes a Sunshine Act, as in America, forcing industry to publicly log all payments made to doctors, teaching hospitals and research institutions.

Meantime, patient campaign groups continue to fight for justice.

# Ducks in a Row

**Sue Robins, Health care activist, speaker and author**

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Should you wait to get all your ducks in a row before patients and staff partner together? My answer is no. Your ducks will never be perfectly lined up anyway, for there is no such thing as perfection when you work with human beings. You might as well start - imperfectly - now.

I worked in two paediatric hospitals in the area of engagement. It was my job to create safe spaces for families to share stories and to participate in decision-making at the organizational level. I helped establish a Family Council and a Family Centred Care Network, started a book club and coached families to share their stories with health professionals. My work also included simple, but significant projects, like swapping the art on the walls so it was more child friendly, and ensuring families had coffee in the common kitchen.

I wrote down all my work stories of both celebration and woe over the

years, and these stories became [Ducks in a Row: Health Care Reimagined](#). It is a scrappy challenge to health care's status quo. I wrote it for people who pine for authentic change.

The pandemic has left health care in rubble. If staff and patient well-being are intertwined, as I believe they are, then how do we rebuild health care together?

The together part is important. I'm grateful to The Patient Experience Library's work because patient experience is key to reimagining health care. For far too long, the patient stories have been dismissed as anecdotal.

As the [Inadmissible Evidence](#) report says, "Medical evidence is taken seriously and embedded in policy and practice. Patient experience evidence - meant to have equal standing - is looked at askance."

It is past time to consider that stories are evidence. My work stories offer evidence that health care should be based on relationships, and dare I say, love. It is about how regular people can use the influence they have to change health care for the better. We don't have to wait for the CEO to give us permission; we can start now.

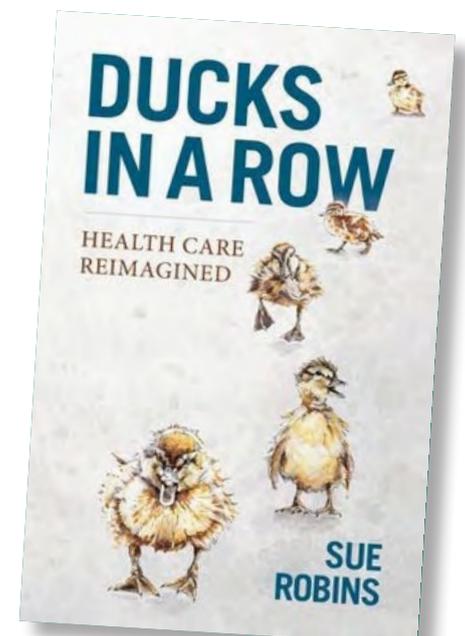
I propose three ways that health care can be reimagined:

- Going out to the people and viewing patient engagement as community outreach opportunities.

- Creating safe spaces for patient feedback - the good, the bad and the ugly. This means honouring storytellers, learning from their stories and taking action.
- Leaning on the arts and humanities to create healing health care environments.

There are plenty of practical suggestions and resources - staff reflective practice sessions, book clubs, patient comforts, healing physical spaces - that can start today.

So while hope is a theme in *Ducks in a Row*, this book is more about action. We have to both reimagine what a new health care world looks like and then take practical steps - right now - to get there. Most importantly, we must do this work together, one little messy duckling at a time.



## RECENT REPORTS

Here, we review our top picks of studies and surveys from the last three months. Some are newly published - others are featured because they shed useful light on recent issues and developments. For full attributions, and copies of the original documents, click on the report pictures. Do you know of a stand-out report that we should be featuring? Contact us! [info@patientlibrary.net](mailto:info@patientlibrary.net)



# Online records - what patients want

This paper starts with a simple statement: "The general practitioner (GP) contract in England states all patients should have online access to their full primary care record".

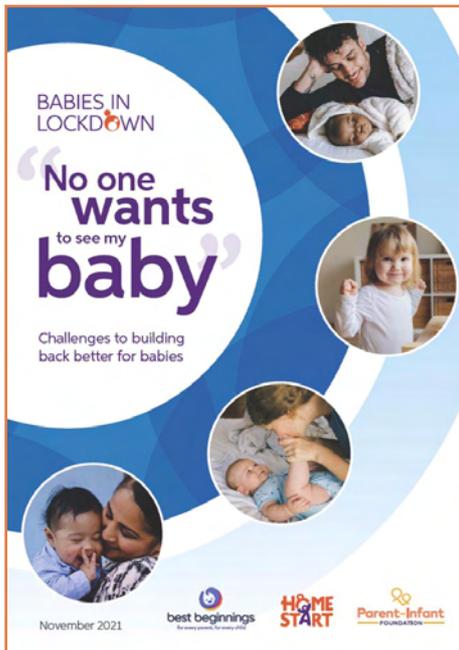
Scratch the surface, however, and things are not so simple. Clinicians worry that online records access (ORA) could cause unnecessary anxiety, increase complaints and threaten confidentiality. There are also fears of widening health inequalities and increased clinician workload.

Against that background, this paper asks what patients want. It found four main themes:

- **AWARENESS:** Study participants felt ORA was poorly advertised, and suggested promoting it via media advertisements, posters in surgeries and during GP consultations.
- **CAPABILITIES:** ORA enabled patients to view test results, medication lists, appointment details, and consultation notes. But participants wanted better presentation, including plain English, links to trusted sources of information, and access via one fully integrated system.
- **CONSEQUENCES:** Some felt that ORA could improve safety by reducing the likelihood that test results would go unnoticed, or enabling them to spot errors in their record. However, others feared safety risks such as unreliable self-diagnosis, self-medication or discouraging clinicians from documenting concerns about mental health or abuse, for fear of upsetting patients.
- **INEVITABILITY:** While there was some resistance to the move towards online services, there was an acknowledgement that much personal data is already held online - for example in the postal system, aviation and online banking.

The authors note further potential for online records access, taking in links with wearable devices, ordering of repeat prescriptions, and the ability to choose between remote and face to face appointments.

The potential, they say, needs to be developed through collaboration between patients, clinicians, policymakers and IT developers. And they conclude that "If we are to meet patient expectations regarding ORA, we need to go beyond simply enabling patients to view information".



## Building back better for babies

The UK Government’s investment in the Best Start for Life vision is, say the authors of this report, welcome. However, “there remains a ‘baby blindspot’ in COVID-19 recovery efforts and a shortage of funding for voluntary sector organisations and core services like health visiting to offer the level of support required to meet families’ needs”.

The report builds on research from 2020 which showed that COVID-19 and the lockdown affected parents, babies and the services that support them in diverse ways. While some families thrived, others struggled, and in particular, “families already facing greater adversity were often hardest hit by the pandemic”.

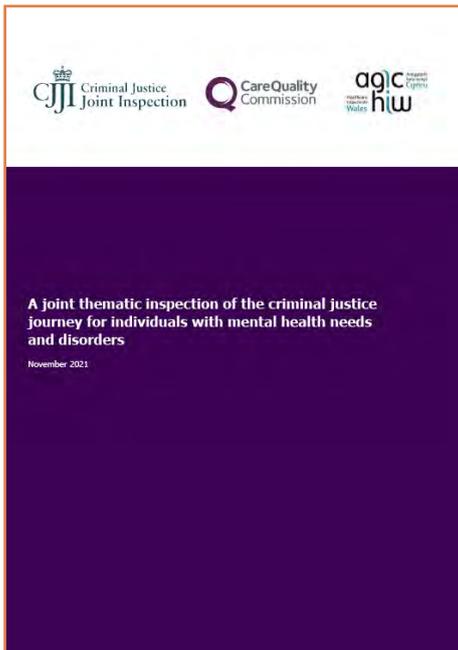
This update finds once again that some families are adapting well, and are feeling the benefits of time together. At the same time, 87% of parents were more anxious as a result of COVID-19 and the lockdown, with families from Black and Asian communities, young parents and those on low incomes reporting higher levels of anxiety.

Many find it difficult to access care, particularly from universal health care professionals like GPs and health visitors. Over a quarter of respondents reported that health visiting routine contacts remain mainly on the phone or online. Nearly a third report that health visitor drop-in clinics that existed before the pandemic no longer operate.

While digital support has an important role to play, remote consultations can make interactions difficult. People wished someone could see their babies in order to provide them with the reassurance that they, as parents, wanted. The report makes three demands:

- The UK Government must support local authorities to invest in and rebuild health visiting services.
- Babies and the services that support them must be included in COVID-19 recovery policy and investment at a national and local level. This must include investment in community and voluntary sector support.
- An evidence-based approach must be taken to ensure the appropriate use of digital and phone-based service delivery, and investment in relational, face-to-face support where this is needed.

“Without urgent action to secure recovery”, says the report, “we fear that the pandemic will leave permanent scars on the provision of support for babies and young children”.



## A hidden injustice

The opener to this report is stark: “Around a third of people who find themselves in police custody have some form of mental health difficulty, as do 48% of men and 70% of women in prison”. And the follow-up is clear: “people with a mental illness need and deserve treatment”.

The report looks at how - and whether - people in contact with the criminal justice system (CJS) are getting the mental health services they need. The answers include these findings:

- There is no common definition of mental health used across the CJS.
- The mental health flagging system used by probation services is muddled.
- Significant problems in information exchange occur in every agency in the CJS.
- Probation practitioners are often hindered by community mental health service providers who do not allow them access to information held on individuals they are working with.
- Prison officers are not supported well in their continuous professional development in working with prisoners with mental health vulnerabilities.
- Prisons continue to be used as a place of safety, and Mental Health Act transfers out of prison custody are taking far too long.

The report contains 22 recommendations which address these, and many other, failings. It calls for most of the recommendations to be completed within 12 months.

The authors cite the 2009 Bradley report, which stated that “failure to adequately address the mental health needs of offenders is a fundamental cause of the chronic dysfunction of our criminal justice system”. They go on to say that “not enough progress has been made in the 12 years since the Bradley review”.

They could also, perhaps, have mentioned [Prime Minister Theresa May's 2017 description](#) of mental illness as a “hidden injustice”, and her call for “parity of esteem” between mental and physical health services. Five years have passed since then, and the goal of parity still seems a long way off.



## Low confidence in government

With over 6 million people now on NHS waiting lists, the Health Foundation's report on public perceptions and expectations of the NHS is timely.

It reveals that the public is pessimistic about the state of the NHS and social care. 57% think the general standard of care provided by the NHS has got worse in the last 12 months, while 69% think the standard of social care services has deteriorated.

Worryingly, less than half think the NHS is providing a good service nationally or locally.

The report states that people's top priorities for the NHS include addressing the workload pressures on NHS staff and increasing the number of staff in the NHS. Clearly, people understand that workforce shortages are a pressing problem. In light of this, say the report's authors, "the continued absence of a comprehensive workforce strategy in England is a glaring omission in the government's plans".

Confidence in government is low: in England, only 9% think the government has the right policies for the NHS, even as it progresses with a major programme of NHS reforms. 58% of the public support raising taxes to spend more on the NHS and social care. But "in the context of a cost-of-living crisis the government will need to keep making the case for the new tax - especially among those who will be paying the most towards it".

The report is the first from a new 2-year partnership between the Health Foundation and Ipsos. They will continue to track public views on health and social care every 6 months.



## A&E - relieving the pressure

Accident and Emergency departments have been [making the headlines](#) in recent months, with pictures of ambulances queuing outside hospitals, and reports of patients waiting up to eleven hours to be seen - far beyond the four hour target.

In this context, this report from the British Red Cross looks at the one per cent of the population who account for more than 16 per cent of A&E attendances, 29 per cent of ambulance journeys, and 26 per cent of hospital admissions. High intensity use costs the NHS £2.5bn per year - but what is driving that cost, and that behaviour?

The study combined literature reviews, data analysis and patient experience work. It showed a clear link between high intensity use and wider inequalities, being associated with areas of deprivation, and issues such as homelessness, unemployment, mental health conditions, drug and alcohol problems, criminality, and loneliness and social isolation.

It turns out that the key to addressing high intensity use of A&E is not so much about “patient flow” or hospital staffing or ambulance services. Instead it is a matter of “addressing the practical, social and emotional issues that can exacerbate people’s physical and mental health conditions, and ensuring that people have timely and appropriate access to support in the community”.

One suggestion is to tackle the “high eligibility thresholds” which can prevent people with serious mental illness from accessing support in the community before reaching crisis point.

Another is to keep an eye on GP attendances. People who attend A&E frequently tend to do the same with other health services, so frequent use of GP services can be an early warning sign of high intensity A&E use.

The report offers a series of recommendations for Integrated Care Systems and national bodies. But it also points to missed opportunities - not least “an ever-shifting, but still widespread, disregard for the importance of addressing people’s wider social determinants of health through de-medicalised care and support”.



# Who examines whom?

For some time now, patients have been increasing their adoption of online platforms as a means of giving feedback to providers. And with the emergence of the “digital health citizen”, the authors of this paper detect a shift in what they call “surveillance”.

At heart is the question of who is examining whom. Traditionally, the “clinical gaze” has been turned by healthcare professionals on patients. Bodies and minds are the subjects of research, physical examination, diagnosis and discussion. But according to the paper, “the gaze is turning, not simply from the patient to the health-care provider, but additionally to the body politic of the NHS”.

This can be uncomfortable for healthcare staff. The paper refers to professionals who “almost universally spoke about the negative feelings online patient feedback elicited in them. This is in spite of evidence showing that most online feedback is positive”.

Other staff were dismissive. By “not engaging with online feedback, staff retained control over... their own account of what good care looked like”.

A further response was to “take control” – for example by directing patients to leave feedback on “legitimate platforms” such as NHS Choices; developing a social media strategy; and designating a staff member with responsibility for managing patient feedback.

But however staff choose to respond, the fact remains that clinicians’ examination of patients is increasingly being matched by patients’ examination of clinicians – and of healthcare as a whole.

Rather than speaking only for the “silent pathology inside their body”, (ie personal illness discussed with the clinician) the patient now also speaks for the “silent pathology inside the body politic”.

By this the authors mean the way that online feedback can be used to air issues that healthcare professionals might feel unable to speak openly about. Examples are waiting times to get an appointment, triaging by reception staff, problems with prescriptions – things that are “indicative of a system straining from years of underinvestment, staff recruitment challenges and increasing workload demands”.

The paper finds that “online review and rating sites, then, are undoubtedly a form of surveillance”. So it is important to remain attentive to how they shift knowledge and power relationships and, potentially, turn the observers into the observed.

Select condition (NHS England categories)

Select treatment type (NHS England categories)

Display as  Headlines  Tables  Charts  xlsx export  All Trusts

Date range  to

Please select up to 10 Trusts for comparison...

## Patients or politics?

NHS England has recently launched the My Planned Care platform, a centrepiece of the elective care recovery plan.

A key part of the platform is a waiting list tracker. Announcing this on the BBC Radio 4 Today programme, Secretary of State Sajid Javid said “For the first time, every patient in England will be able to go on line and see where they are on the waiting list”. He said it would offer “a level of transparency that has never been provided before”.

Unfortunately My Planned Care does nothing of the sort. All it can offer patients is one rather unhelpful statistic: average waiting times for treatments at local Trusts.

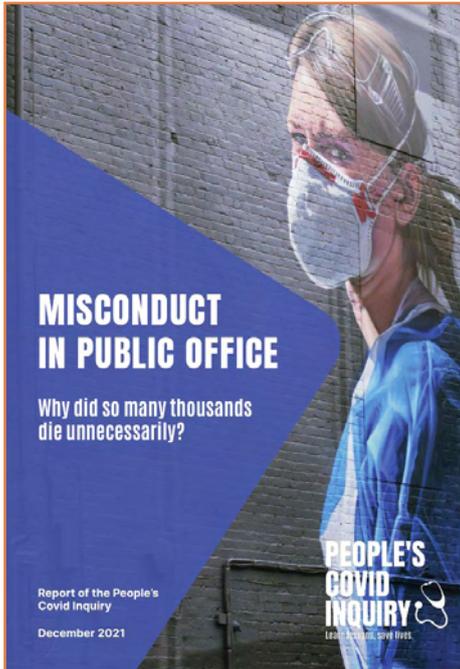
Our own [waiting list tracker](#) has been available free of charge across all English acute Trusts since the middle of last year. It offers median waiting times, trends data, numbers waiting at the 18 and 52 week thresholds - and all of this with instant Trust-by-Trust comparisons. NHS managers can download data to Excel spreadsheets for further analysis. Patients can print off headlines as a handy aide-memoire.

We have repeatedly asked NHS England officials to work with us on raising awareness of our tracker. Instead they have spent eight long months creating their own much less useful version.

Our waiting list tracker was developed with £5k of funding, and is available entirely free of charge for every acute Trust in England. We have asked how much the My Planned Care tracker cost to develop, but no-one will tell us.

So what is the point of My Planned Care? It is hard to resist the conclusion that it is more about political window-dressing than a genuine attempt to help patients.

Our offer to NHS England remains open: please work with us. And in the meantime, we will continue to innovate, but will do so with patients in mind, not politics.



## Covid inquiry limbers up

It is good to see the launch of a public consultation on the Covid Inquiry's [draft terms of reference](#). The inquiry will make a formal assessment of the government's pandemic preparedness and response.

So now seems a good time to revisit the report of a Covid inquiry that has already taken place. Published in December 2021, the People's Covid Inquiry makes no bones about its conclusions. The title alone: "Misconduct in Public Office" indicates its main thrust.

On preparedness, some key findings are as follows:

- Austerity policies from 2010 onwards resulted in widening health inequalities. Once Covid struck, there was a "very, very high differential mortality gradient where the most disadvantaged groups have clearly been most vulnerable".
- Contingency planning for emergencies such as pandemics was "stripped out" after 2010, with "local agencies left to make their own arrangements".
- Austerity and marketisation meant that by 2019 the NHS was short of 100,000 staff and had "one of the lowest beds-to-patient population ratios in Europe".

On responsiveness, the inquiry found that:

- For a long period there was no functioning "Find, Test, Trace, Isolate and Support" system. The Government had already abandoned widespread testing by March 2020, due to a lack of capacity.
- Stocks of personal protective equipment (PPE) were "massively run down" before the pandemic. Staff were photographed wearing bin bags and other makeshift items, and this played "a significant role in hospital acquired infection".
- Government messaging was often unclear, confusing, contradictory or just plain wrong. Messaging for minority ethnic groups had been "poor to non-existent".

There is much more in this report - on corrupt contract processes, the experiences of "at risk" groups, human rights issues and more. In spite of all this, the report states that "It is not too late for some good to emerge from the pandemic".

It says that "Lessons are clear, and can and should be learned. With political will and public support, social and health inequalities could be tackled. We could see the NHS and other public services properly funded saved from the brink of collapse. Only in this way can we keep the nation safe and protect it from a repeat of the current catastrophic public health disaster we have documented here".

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ORIGINAL ARTICLE

SOCIOLOGY OF HEALTH & ILLNESS

**'I'll put up with things for a long time before I need to call anybody': Face work, the Total Institution and the perpetuation of care inequalties**

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**Abstract**

Failures in fundamental care (e.g. nutrition or pain-relief) for hospitalised patients can have serious consequences, including avoidable deaths. Policy rhetoric of 'shared decision-making' fails to consider how structural constraints and power dynamics limit patient agency in nursing staff-patient interactions. Goffman's concepts of face work, the presentation of self and the Total Institution shaped our analysis of interview and focus group data from hospital patients. Patients avoided threatening 'good' patient and staff face by only requesting missed care when staff face was convincing as 'caring' and 'available' ('engaged'). Patients did not request care from 'distracted' staff ('caring' but not 'available'), whilst patient requests were ignored in Total Institution-like 'dismissive' interactions. This meant patients experienced missed care with both 'distracted' and 'dismissive' staff. Patients with higher support needs were less able to carry out their own missed care to protect staff face, so experienced more serious care omissions. These findings show that many elements of the Total Institution survive in modern health-care settings despite attempts to support individualised

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# Fundamental care and difficult patients

“Missed fundamental care in hospital can have serious consequences”, says this paper. It references the Mid Staffordshire inquiry, whose Chair, Sir Robert Francis QC, described apparently minor failures (personal cleansing, dressing, toileting, eating and drinking etc) as the “early warning signs” of what turned into “appalling suffering”.

The authors cite other research, indicating that when patient need exceeds labour resources (ie at at time of workforce shortages), medical care tends to be prioritised, with implicit rationing of both emotional support and aspects of ‘fundamental care’. In spite of this, “patients can be reluctant to ask for care for fear of being labelled difficult”.

The study explored these issues, and found that patients talked about “staying out of trouble” and “not wanting to make a nuisance” or “pester staff”. They tended to keep an eye on nursing staff to decide whether and how to ask for help with their fundamental care needs.

Patients’ views of staff behaviour fell into three types: “engaged” nurses were seen as genuinely attentive and caring. “Distracted” nurses could be caring but were not generally attentive. “Dismissive” nurses were seen as neither caring nor attentive.

The nurses’ work environment seems to have played a part. They were seen as less “engaged” on a ward which had a high number of beds, a high turnover of patients and was undergoing a significant reorganisation during data collection. Staff were more “engaged” on a long stay ward, where patients had existing relationships with many members of staff. Importantly, “dismissive” care was most closely identifiable with aspects of the “Total Institution”, where “batch living”, standardised routines and institutional efficiency can come to override personalised care.

The consequences for patients are worryingly reminiscent of Mid Staffs. In some cases, “they would wait to make fundamental care requests... waiting until the next shift if necessary”. But sometimes “they stopped asking for care because they felt it would not be given”.

The study notes that “patients who were most in need of physical support and patients with cognitive impairments experienced serious omissions of care”. And it finishes by stating that unless nursing staff can maintain an “engaged” interaction with patients, the idea of “patient involvement in hospital care decisions will remain at the level of rhetoric”.

# H HEALTHCARE CONFERENCES UK

## Patient Involvement & Partnership for Patient Safety

**FRIDAY 6th MAY 2022**

**VIRTUAL, Online**

This conference focuses on patient involvement and partnership for patient safety including implementing the New National Framework for involving patients in patient safety, and developing the role of the Patient Safety Partner in your organisation or service.

This conference will enable you to:

- Understand how to implement the June 2021 National Framework for Involving Patients in Patient Safety
- Improve the way you recruit, work with and support Patient Safety Partners
- Develop your skills in embedding compassion and empathy into patient partnership
- Understand how you can improve patient partnership and involvement after serious incidents
- Identify key strategies for support patients, their families and carers to be directly involved in their own or their loved one's safety
- Learn from case studies demonstrating patient partnership for patients safety in action
- Examine methods of involving patients to improve patient safety in high risk areas
- Self assess and reflect on your own practice
- Gain CPD accreditation points contributing to professional development and revalidation evidence

### Further information and booking

or email [kate@hc-uk.org.uk](mailto:kate@hc-uk.org.uk)

Twitter



## NHS Complaints Summit

**WEDNESDAY 8th JUNE 2022**

**VIRTUAL, Online**

This National Virtual Summit focuses on the New National NHS Complaint Standards that were published in March 2021 and are due to be introduced across the NHS in 2022. Through national updates, practical case studies including NHS Complaints Standards early adopters sites, and in depth expert sessions the conference aims to improve the effectiveness of complaints handling within your service, and ensure that complaints are welcomed and lead to change and improvements in patient care.

The conference will also reflect on managing complaints regarding Covid-19 – understanding the standards of care by which the NHS should be judged in a pandemic and in particular responding to complaints regarding delayed treatment due to the pandemic.

### Further information booking

or email [kate@hc-uk.org.uk](mailto:kate@hc-uk.org.uk)

Twitter

## Measuring, Understanding and Acting on Patient Experience Insight From Insight to Improvement

**WEDNESDAY 6th JULY 2022**

**VIRTUAL, Online**

This conference will focus on measuring, understanding and acting on patient experience insight, and demonstrating responsiveness to that insight to ensure Patient Feedback is translated into quality improvement and assurance. This is particularly important during Covid-19 where feedback and engagement is key in identifying opportunities to create the best possible experiences for patients and carers, who are often accessing services during difficult times for themselves and their families.

Sessions will include learning from patients, improving patient experience during and beyond Covid-19, delivering a patient experience based culture, measuring patient experience, using the NHS Improvement National Patient Experience Improvement Framework, demonstrating insight and responsiveness in real time, monitoring and improving staff experience, the role of human factors in improving quality, using patient experience to drive improvement, changing the way we think about patient experience, and learning from excellence in patient experience practice.

### Further information and booking

or email [kate@hc-uk.org.uk](mailto:kate@hc-uk.org.uk)

Twitter

# Confused?



Patient experience evidence comes in different formats at different times from multiple sources. It is hard to make sense of it all.

## We can help you with...

**LIBRARY SERVICES:** Free access to the [Patient Experience Library](#), [Healthwatch maps](#) and [Quote Selector](#).

Struggling to keep track of local reports from public meetings, focus groups, surveys, Healthwatch, Maternity Voice Partnerships, Cancer Alliances etc? Ask us about tailor-made local libraries for your Trust or Integrated Care Partnership.

**EVIDENCE SERVICES:** Free access to [research-based publications](#). Need to contextualise your own local evidence gathering? Ask us about bespoke search and literature reviews like [this](#) and [this](#).

**ANALYTICS:** Free access to our [Patient Surveys Tracker](#) and [Waiting Lists Tracker](#). Looking for more like this? Ask us about customised analytical tools to support your insight and engagement work.

Get in touch! [info@patientlibrary.net](mailto:info@patientlibrary.net)

# The Patient Experience Library

We are the national evidence base for patient experience and patient/public involvement. We have collated and catalogued over 70,000 reports and studies from government bodies, Healthwatch, academic institutions, think tanks and health charities.

[Visit our website](#) to get free access to evidence and analytical tools.

You can see more about who we are and what we do [here](#).

We welcome copy from contributors for the “Comment” section of this magazine, but cannot guarantee publication and we reserve the right to edit for reasons of space or style. Drop us an e-mail to receive our guide for contributors: [info@patientlibrary.net](mailto:info@patientlibrary.net)

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