

Every Touchpoint Matters: Developing a Systematic Tool to Measure the Impact of Hospice Services upon Patients, their Families and Carers.

Lynn Sudbury-Riley, Pippa Hunter-Jones, Laura Menzies, Mike Pyrah & Helen Knight

7th International Research Meeting in Business and Management (IRMBAM-2016)

11-12 July 2016, Nice, France.

Abstract

This paper details the development of a measurement tool used in a collaborative (University and Hospice) project designed to measure the impact of hospice services upon patients and the people who care for them. The study was conducted in conjunction with East Cheshire Hospice in England. The Hospice provides specialist palliative care for people with progressive life-limiting illnesses, providing services to patients, carers and families via inpatient and outpatient units and day facilities. Striving for excellence, the project reflects the Ambitions for Palliative and End of Life Care collaborations to find ways of delivering better care. However, existing feedback collected by East Cheshire Hospice from patients and their families left no room for improvement. Using Service Blueprinting as a starting point, the team designed a new qualitative research tool to follow the user's experience at every touchpoint in their journey. Interviews with 38 in-patients, outpatients, visitors and bereaved families enabled a 'deep-dive' to uncover perceptions of the whole service experience among these diverse users. Results of this new approach suggest the technique fully captures the hospice experience and informs areas for improvements to hospice care.

Introduction

Just as manufacturing firms aim for zero defects, service providers strive to avoid service failures where customer expectations are not met. However, because services comprise unique human interactions, service failures are almost inevitable. Consequently, organisations focus on service recovery strategies to fix problems and retain their customers for the future. Because a hospice offers care to terminally ill patients, it may not get the opportunity to correct a service failure. This situation makes the identification of what hospice users really need and want, and to ascertain perceptions of the hospice's service delivery from the user's perspective, even more important than for other service providers.

A well-documented and fundamental barrier to improving end-of-life care is a lack of service quality measurement tools that capture the experiences of user's from their own perspective (Teno et al., 2002). In palliative care, many quantitative measures are used and these tend to focus on issues

such as how quickly patients are assessed, whether they receive information leaflets, whether a discussion about their emotional needs is documented, and so on. Consequently, quality of service from the user's perspective is overlooked (Pasman et al., 2009). The current study was designed to overcome these limitations by developing a tool to measure the user's experience at every touchpoint in their journey from referral to the hospice to either post-discharge or bereavement.

The paper begins with an overview of hospice service provision, before outlining the many measurement tools available to collect data on the patient experience. It then explains the development of the new measurement tool and its application in a specific hospice setting, where in-depth interviews with inpatients, outpatients, carers and families uncovered rich data which allows for better understanding of those service areas that meet or exceed user's expectations, as well as identifying areas for improvement. The benefits of the new tool over existing measurement techniques are discussed.

Hospice Service Provision

Hospices provide end-of-life or palliative care to people with a terminal illness. The World Health Organisation (WHO) defines palliative care as "an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual" (WHO, 2015). The demand for hospice care is on the rise: with an ageing population, there is a greater need to access end-of-life care (Candy et al., 2011).

In the UK, there are over 200 hospices, supporting around 120,000 patients annually (Hospice UK, 2015). Hospices aim to provide emotional and physical comfort to patients as they reach the end of their life, taking a holistic view of the needs of the patient and their family. Admission into a hospice implies that the patient's focus has shifted away from being cured, towards acceptance of end-of-life, leaving them with hope for the best quality of life in their final days (Myers, 2002; Waldrop and Rinfrette, 2007).

East Cheshire Hospice (ECH) accepts referrals from patients registered with doctors in its local area, dependent upon individual circumstances. Referral criteria reflect the work of ECH as a provider of specialist palliative care for patients with progressive life-limiting illnesses such as metastatic cancer, organ failure or neurological disorders. Support extends to carers and families. ECH delivers this care through an Inpatient Unit, an Outpatient and day facility (Sunflower Centre), programmes (e.g. Living Well) and clinics (e.g. Breathlessness Clinic and Lymphoedema Clinic). There is some Government funding, but 80% of costs are met by the hospice itself via fundraising.

ECH strives for excellence in service and the patient experience. Anecdotal stories and other forms of feedback provide plenty of evidence that the work of the hospice is meaningful. However, ECH did not have any systematic, robust way of capturing these experiences. Hence, while ECH was often told it had transformed the experience of patient's at the most critical time in their lives and that it was needed and appreciated by many service users, there was nothing but anecdotal evidence to

back up this feedback. Worried that such superb feedback could actually lead to complacency, the team at ECH commissioned the University to undertake a 'deep-dive' of the impact of hospice care upon the different inpatient and outpatient service users associated with ECH.

Patient Feedback

Research pertaining to the general healthcare sector indicates that patient feedback is seen as a necessary, desirable, even essential feature of improving the quality of healthcare delivery. It is positioned as a function to improve patient and clinician communication, minimise patient dissatisfaction and enhance patient empowerment. Such feedback is seen as a mechanism for changing healthcare processes, building trust and confidence and for improving clinical performance with the ultimate goal of achieving better healthcare outcomes (Department of Health, 2009; NHS Confederation, 2010). Such discourse represents the 'person-centred' care and 'mutual' health care positioning so pivotal to quality enhancements (Department of Health, 2013).

However, collecting healthcare feedback is acknowledged as problematic. One particular criticism levied at the sector more generally is linked to the lack of systematic data collection processes. Attempts to measure patient experiences have been hindered by an abundance of measurement instruments which use a myriad of outcome measures with different degrees of psychometric development and testing (Beattie et al., 2014). Traditional survey type tools include, but are not limited to: the Consumer Assessment of Health Plans Survey; the Hulka Patient Satisfaction with Medical Care Survey; the National Centre for Quality Assurance's Member Satisfaction Survey; Patient Judgements of Hospital Quality; The Outpatient Satisfaction Questionnaire; Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey; The National Patient Survey Programme; GP Patient; 18 weeks; National Patient Choice surveys; Patient Satisfaction Questionnaire; GPAQ; and the National cancer patients' experience survey programme.

A second problem is that there appears to be a mismatch between the objectivity of the survey and the attitudes and experiences of the medical professionals who should be utilising the feedback (The Health Foundation, 2013). For example, one study identified that the majority of doctors interviewed expressed doubts about the credibility of the results from the General Practitioner (GP) Patient survey, arguing that it provided insufficient detail to stimulate change (Asprey et al., 2013).

Specific tools to capture the patient experience in palliative care are equally problematic. First, most instruments were developed for other healthcare contexts, with very few specifically designed for palliative care (Sulmasy et al., 2002). Second, many of the key terms in palliative care, such as quality of life, spirituality, dignity, and resilience are not well understood or clearly defined (Simon et al., 2012). Hence there is a lack of quality indicators in end-of-life care, leading to some key areas of palliative care often not being fully assessed (Dy et al., 2015). Of course, this is a barrier to improvement (Pasman et al., 2009) and also means there is substantial variation in the quality of the end-of-life care that people receive (Care Quality Commission, 2015). Third, while numerous studies have attempted to identify outcome measures for palliative care (De Roo et al., 2013; Evans et al., 2013; Schenck et al., 2010), these quantitative outcomes fail to capture overall patient experience, and instead focus on measuring outcomes such as how quickly patients were assessed, whether they

received information leaflets, whether a discussion about their emotional needs was documented, etc. Whilst these aspects are important, they provide little information about how the patient felt.

Finally, there are specific difficulties in capturing data in order to fully understand hospice service experiences. Patients tend to base their perceptions of the care they receive solely on the basis of the interpersonal relationships they have with hospice care providers, hence they tend to agree that the care they receive is responsive to their needs (Churchman et al., 2014). Therefore there is an issue of validity due to these extremely subjective perceptions (Casarett, 2005). Participant attrition is high because people receive hospice care only when their health is deteriorating to the point where death is often imminent (Candy et al., 2011). There is also a prevailing view that because patients in hospices are receiving end of life care they are too vulnerable to participate in research, which has stunted the growth of evidence-based research in this area (Casarett et al., 2005; Gysels et al., 2012; Wallace, 2015). These specific data collection problems mean that a significant proportion of the research conducted into the quality of hospice care uses family members, carers or staff, rather than the patients themselves. Yet, "The real test of performance by...any healthcare provider must be the views and experiences of its users. By asking patients in a rigorous, systematic fashion about their experiences of care and treatment, healthcare services can be accurately measured and improvements made" (Picker Institute Europe, 2009). It was with a focus on asking patients, carers and families about their experiences of care and treatment received at ECH, in a rigorous and systematic fashion, with the purpose of accurately measuring performance and uncovering opportunities for improvement, that the current project was born.

Development of the Touchpoint Tool

Originally, the researchers had intended to use service blueprinting in the project. Initially developed as a mapping technique to help visualise intangible service systems from the customer's perspective (Shostack, 1987; Polonsky and Garma, 2006), the concept was later refined into a powerful technique that can be used to depict a service at multiple levels of analysis. That is, service blueprinting can facilitate the detailed refinement of a single step in the customer process as well as the creation of comprehensive, visual overview of an entire process" (Bitner et al., 2007:4). Service blueprinting is a customer-focused approach for service innovation and improvement, where the 'onstage' visible service user and provider interactions must be supported by the 'backstage' employee actions and support processes (Bitner et al., 2007). Physical evidence, or the so-called servicescape (Bitner, 1992) is also important when blueprinting a service. Hence, a service blueprint entails breaking down a service into its logical components, establishing the different steps in the service process, and then examining how these steps are executed in order to ascertain how the user experiences the service (Zeithaml et al, 2006).

The service blueprinting literature has traditionally focused on businesses in the private sector. However, it has been argued that this approach is even more relevant to the not-for-profit sector due to growing pressures to deal with a wide range of increasingly reliant customers (Polonsky and

Garma, 2006). Indeed, austerity pushes non-profit organisations to deliver services more effectively and efficiently. Yet there are only two known applications of using service blueprinting in a healthcare context. The first found that service blueprinting of the facilities management process for a hospital stay helped to improve transparency and coordination across the service (Coenen et al., 2011). The second used the technique to examine a hospital's quality management system, and concluded that it was an effective method to help improve resource allocation and process efficiency (Chen and Cheng, 2012). Both of these studies did, however, use a mixed methods approach when using the service blueprint technique. The current study is the first to utilise the technique in a hospice setting. This is also the first known study to utilise service blueprinting solely from a qualitative perspective, in order to avoid the many drawbacks of the quantitative tools outlined in the previous section, and to ensure that the project really did collect the views and experiences of the hospice's users, from their own perspective.

The current project is not the first to discover that service blueprinting is a complicated activity when attempting to ensure a standardised procedure that is at the same time flexible enough to satisfy customer's individual needs (Kostopoulos et al., 2012). As Bitner et al. (2007) note, a lot of information is required about customers and the service process, and this must be collected in a structured manner in order to ensure the blueprint covers all critical aspects of the customer experience. Hence, by the time the research team had fully mapped service provision at ECH from a user's perspective, the resulting blueprint was cumbersome, complicated, too large and far too complex to be used effectively. Indeed, it was obvious that this full blueprint was too complex to explain to the staff at ECH, let alone be presented as an aide-memoir in order to guide respondent's story-telling of their whole ECH journey experience.

Despite this size and complexity, the finished blueprint was lacking in two crucial areas. First, key issues that are central to palliative care services such as enhancement of quality of life, spirituality, dignity, and resilience (Simon et al., 2012) were missing. Intangible service elements are, of course, an integral aspect of service blueprinting, but these crucial areas of palliative care are perhaps so abstract that they did not easily emerge when blueprinting the hospice services. Second, by following the blueprinting process, the ECH service began at admission and ended with discharge or death. In other words, a service blueprint contains a single service journey with the particular service provider. However, due to the nature of this service, a hospice user must access other service providers (GPs, MacMillan nurses, other healthcare providers) in order to be referred to the hospice in the first instance. Indeed, when referring to health care services, "a person's experience starts from their very first contact with the health and care system, right through to their last" (NHS National Quality Board, 2015). Thus service blueprinting is lacking in that it fails to acknowledge the system's connections and collaborations with other services. Yet these interconnections are crucial for hospice care provision. Additionally, the journey continues with after-care treatment plans, bereavement counselling, and other support mechanisms. Hence, while being too large, too complicated, and too cumbersome, the service blueprint for ECH was also limited, restrictive and incomplete. In other words, service blueprinting was simply not fit for purpose in terms of mapping a hospice-user's journey. Certainly, it was not fit for purpose to take the deep-dive approach needed to uncover experiences from the user's perspective.

The blueprinting exercise was useful, however, in terms of highlighting the complexity and multidimensional aspects of every service touchpoint. The next step, therefore, was to make each of

these complex touchpoints easy to understand for users. The team were mindful that in the case of patients, all would be seriously ill and many would be incredibly fatigued, while their families and friends were likely to be anxious, worried or even recently bereaved. Rather than have a blueprint that, as suggested by Bitner et al. (2007), comprises five major sections depicting the physical evidence, the customer actions, the onstage/visible contact employee actions, the backstage/invisible employee actions and the support processes, these were stripped down into a number of touchpoints solely from the user's perspective. Hence, while "onstage/visible contact employee actions" were an important part of each touchpoint, respondents did not need to discuss these separately from the "backstage/invisible employee actions" and the "support processes". Rather, what was needed was a research tool that collected their experiences, thoughts, feelings and reflections at each stage in their journey. Of course, at each stage of this journey, there may be all of these five service blueprint elements present, but what was needed was a tool that collected perceptions from the user's perspective.

Methods

The Touchpoint Trajectory Tool

What emerged from the blueprinting exercise and the subsequent attempts to make it user-friendly and fit-for-purpose in a hospice setting was a tool that captured each section of the journey: a touchpoint trajectory that mapped out every aspect of the service from the initial referral process (which of course acknowledged the interconnections with other healthcare providers), right through to the present day. The present day for some users entailed being an inpatient in a hospice only a few days from death, while the present day for some relatives comprised a state of grief and the receipt of support mechanisms. Each major touchpoint also allowed for the collection of data important to the user: the tool had to provide opportunities for users to talk about the key issues central to palliative care: issues such as quality of life, spirituality and dignity.

At the same time, the team were mindful that this project had the potential to be extremely stressful and upsetting to respondents. Consequently, it was decided that each touchpoint could be depicted by a number of pictures and easy-to-recognise signs and symbols to act as an aide-memoir for users as they told their story of their journey through each service touchpoint. The team decided to use, where possible, animated pictures, again hoping this would make the exercise more accessible and less formal. The focus of the discussion was grave and stressful, but the tool did not have to add to those emotions. The animated pictures, signs and symbols for each touchpoint were then printed in colour onto large laminated cards, each of which could be placed in front of the respondent to act as an aide-memoir as they told their stories of their experiences. Respondents were free to use all, none, or some of the pictures, signs and symbols in order to guide their storytelling. The major touchpoints identified are shown in table 1, with an overview of the different pictures and symbols that each touchpoint card contained.

Table 1: Trajectory Touchpoints

Touchpoint	Pictures, Signs & Symbols
Pre-Arrival. Information & Referral	Referral process; Questions & Answers; Support; Human interaction; Telephone; Internet; Social Media; Advice; Leaflets; Website
Arrival & Admissions Process	Signposting; Parking; Welcome; Reception; Receptionists; Booking Systems; Information Availability; Knowledge, Attitude & Skills of Staff; Trust; Kindness
Accommodation & Comfort	Rooms; Bed; Bathroom; Television; Radio; Telephone, Internet signal; Overall comfort & facilities
Clinical Support	Doctors; Nurses; Care Plan; Pain Management; Physiotherapy; Art Therapy; Counselling; Tai Chi; Trust; Professionalism; Communication
Food	Availability; Room service; Choice; Menu; Presentation
Cleanliness	Standards; Cleaning regularity; Smells
Little Extras	Chapel & Spirituality; Library; Spa services; Hair Salon
Shared Spaces	Courtyard; Tea Room; Relatives Room; Noise; Other People
Discharge/After Care	Support, help, guidance, assistance, advice; Discharge planning; The discharge process; After care

After an initial introduction and reassurance that the researchers were completely independent to ECH and that all interviews would be anonymous and in strictest confidence, it was explained to respondents that it was their words, their feelings, their perceptions that mattered. There were no right or wrong answers. In fact, there were few general questions. Rather, each of the touchpoint cards was placed in front of the respondent, beginning with the pre-arrival card, to help respondents to focus on their ECH journey from the beginning to the present day. For some respondents, therefore, the final card was not relevant. The in-depth interviewing technique allowed for probing of issues and examples, but asked few general questions. Interviews were recorded and transcribed verbatim.

Sample

The sample (n = 38) comprised 18 patients (current inpatients, outpatients and 3 discharged patients), 12 users drawn from the family and friends of patients (6 belonging to inpatients and 6 belonging to outpatients), and 8 bereaved family members. A demographic profile of these respondents is presented in table 2.

Table 2: Demographic Characteristics of the Sample

Affiliation with Hospice	Age Group	Gender	Marital Status	SES
Inpatient	50-54	Female	Partner	DE
Outpatient	80-84	Female	Widow	DE
Outpatient	75-79	Male	Single	AB
Outpatient's carer	55-59	Male	Married	AB
Inpatient	90+	Female	Widow	DE
Inpatient (Day)	85-89	Male	Married	AB
Inpatient's carer	40-44	Female	Married	C1
Outpatient	75-79	Female	Married	DE
Outpatient	75-79	Female	Married	C1
Outpatient	55-59	Male	Married	C2
Outpatient	70-74	Female	Separated	AB
Outpatient	80-84	Female	Widow	C1
Outpatient	65-69	Female	Married	AB
Outpatient's carer	50-54	Female	Married	C2
Inpatient's carer	50-54	Female	Married	AB
Outpatient's carer	65-69	Male	Married	AB
Outpatient	65-69	Male	Married	AB
Outpatient	65-69	Female	Divorced	AB
Outpatient's carer	70-74	Male	Married	AB
Inpatient's carer	85-89	Male	Married	C1
Inpatient	80-84	Female	Married	C1
Inpatient	80-84	Female	Widow	C1
Inpatient's carer	65-69	Male	Married	C1
Outpatient's carer	65-69	Female	Married	C1
Outpatient's carer	70-74	Female	Married	C1
Inpatient's friend	65-69	Female	Married	C1
Inpatient's carer	50-54	Female	Married	C1
Bereaved family	75-79	Female	Widow	AB
Bereaved family	60-64	Female	Widow	C1
Bereaved family	45-49	Male	Single	AB
Bereaved family	70-74	Female	Widow	AB
Bereaved family	70-74	Female	Widow	AB
Outpatient discharged	70-74	Female	Widow	AB
Bereaved family	50-54	Female	Married	C1
Bereaved family	70-74	Female	Widow	C1
Bereaved family	60-64	Female	Widow	AB
Outpatient discharged	45-49	Female	Single	AB
Outpatient discharged	65-69	Female	Single	C1

Results and Discussion

This 'deep dive' into the individual's experiences of their ECH trajectory resulted in over 104,000 words of data which was subsequently subjected to extensive thematic analysis. While the full results are beyond the scope and focus of the current paper and will therefore be presented

elsewhere, a brief overview of some preliminary results is presented. What is important to the context of the current paper is not the results themselves, but the fact that the new tool did reveal opportunities for improvement, which is a major contrast to the findings of the data previously collected using quantitative tools and anecdotal evidence.

Results did reveal many excellent aspects of service delivery by ECH. Indeed, results identified multiple instances of excellence embedded throughout the services the hospice offered. Staff are appreciated, respected and do a brilliant job. They frequently go above and beyond what people expect. *"They greeted you like long lost friends and really helped you through what was a very difficult time"*. The ability of the hospice setting to facilitate teamwork amongst staff was appreciated by a number of respondents: *"They each know what each other was doing. You felt like you were talking to a team and you don't always get that"*. ECH makes people feel welcome, safe, and most importantly people trust the services that are offered: *"From the moment he sat down she said "you don't look comfortable there, do you need a blanket?" straight away. Straight away I just took a deep breath and thought phew, they are looking after him!"* The study revealed that ECH is responsive and make a difference to the lives of not only patients, but families and carers too: *"...he moved into a single room ... it meant that his little grandchildren could come and see him... there was a nice lounge, as they were only two and four they could go in for a few minutes and then go and play in the lounge ... they didn't get overwhelmed"*. Importantly, the technique also revealed spiritual and emotional issues relevant to palliative care, which has been lacking in other tools: *"it is an incredibly important emotional support for him, to be honest I don't know where we would be if we didn't have it, thank God we do have it."*

The study did reveal many instances where service provision could be improved. Indeed, the detailed stories, encompassing each major touchpoint in the trajectory, told by 38 individuals in their own words, revealed areas for improvement at each stage. Many of these are easy to implement (and have indeed been implemented already by ECH). What is most important in the current context is that these areas had not emerged when using alternative data collection methods.

In terms of pre-arrival, it emerged that hearing about ECH is often serendipitous. One carer spoke of being at the hospital when she *"spotted a leaflet – I don't know why the GP had not mentioned it – we needed it earlier – a lot earlier... because we have struggled"*. Others spoke of the lack of information provided by other healthcare providers: *"We went back to the hospital and asked for some help because we really felt like we had been left on our own"*. The information that is available is useful, but in terms of the website, for example: *"not everyone is computer savvy, you know... we were able to look it up but he doesn't go on the computer...and in the first instance you don't know what's going to happen"*. Already, there are moves in place to discuss such issues with other healthcare providers. The interconnections between this service and the services that come before hospice provision need to be examined and improved.

Arrival and admission is usually easy and seamless, often accompanied by a sense of relief, confidence in the staff, and a major contrast to the hospital experiences that users are used to. Nevertheless, the accounts revealed that if people don't live locally and don't know where ECH is, finding it can be a bit of a worry: *"it's obviously kind of signposted but the trees grow over the signs this time of year"*. When people first arrive, they get a fabulously warm welcome - but knowing who is who is a bit daunting: *"they introduced me to everybody, and then it was the hard bit of*

remembering names, getting them all right!" Trees have already been cut down to enable people to read the signs and therefore eradicate the stress caused by feeling lost when going to somewhere that is already terrifying for some people. Further work is being done to probe perceptions of name badges, posters with photographs of staff and their names, or pictures of uniforms to explain the different staff and who they are.

Preferences for single rooms over shared wards appear to be dictated by the individual, their personality and sociability, with one family commenting: *"she was not a particularly social person...a shared ward was a problem"* while for one inpatient in a single room: *"the first couple of nights I was a bit lonely... I felt a bit at the end of the queue"*. Hence ECH need to try to accommodate these individual preferences as much as is practically possible.

In terms of clinical and support services, quite a number of patients and carers opened up about depression and expressed a desperate need for more counselling: *"I think the counselling sessions could be longer. I feel that maybe that's too rushed?"* And a very difficult area, but one that needs to be discussed and procedures put in place is the issue of clarity of communication to the relatives of the dying: *"looking back I think I know what was going on...they said a few times if I'd like to stay that night... I'd said I'd have a think and went home...when I came back they said it again and I thought they were trying to tell me something"*

There are some issues with bereaved families having to go back to collect death certificates: *"my son was off work....I don't know if I'd have been in the right state to go back"*. ECH will now offer the option to have the death certificate delivered by a volunteer to bereaved relatives if they think coming back to the hospice so soon is too traumatic.

Finally, in contrast to the prevailing view that because patients in hospices are receiving end of life care they are too vulnerable to participate in research (Casarett, 2005; Gysels et al., 2012; Wallace, 2015), the study revealed that patients and their families were impressed that the hospice had taken the trouble to invest in the study, perceiving it as another indication that ECH cares about its users: *"it shows that you people appreciate me and you are listening"*

Conclusions

This paper has presented an overview of the development of a new hospice trajectory tool, designed to enable a 'deep dive' to probe the perceptions and experiences of the journeys taken by different hospice users from pre-admission to discharge or bereavement. The tool emerged from service blueprinting (Bitner et al., 2007) which proved to be an excellent starting point. However, perhaps given the special nature of palliative care, on the one hand service blueprinting failed to incorporate the interconnections between hospice provision and other healthcare providers, as well as the crucially important but admittedly abstract concepts such as spirituality, dignity, and quality-of-life. On the other hand, the completed service blueprint for the hospice was overly complex and too large to use effectively. The touchpoint trajectory tool was not difficult to use. Indeed, its use of easily recognised signs and symbols, together with animation, made for these in-depth interviews to be conducted in an easy and relaxing manner, despite the content of many of these discussions

being distressing and upsetting. The tool put people at ease, enabled the interviewers to come across as friendly and not too formal or overbearing, and most importantly enabled respondents to talk about their journeys in a systematic manner. Unlike the myriad of quantitative tools that tend to be used to collect patient data, this new touchpoint trajectory tool uncovered many areas for service delivery improvement. In sum, the new tool is fit for purpose. The Picker Institute Europe (2009) stresses the need for patients to provide their views and experiences in a rigorous and systematic fashion, as only in this way can healthcare services be accurately measured and improvements made. The new measurement tools answers this call.

References

- Asprey, A., Campbell, J.L., Newbould, J., Cohn, S., Carter, M., Davey, A., Roland, M. (2013) Challenges to the credibility of patient feedback in primary healthcare settings: a qualitative study. *British Journal of General Practitioners*; 63(608):200- 208.
- Beattie, M., Lauder, W., Atherton, I., & Murphy, D. J. (2014). Instruments to measure patient experience of health care quality in hospitals: a systematic review protocol. *Systematic reviews*, 3(1): 1-8.
- Bitner, M. J. (1992) Servicescapes: The Impact of Physical Surroundings on Customers and Employees. *Journal of Marketing*, 56: 57-71.
- Bitner, M. J., Ostrom, A. L. and Morgan, F. N. (2007) Service Blueprinting. A practical technique for service innovation. Arizona State University: Centre for Services Leadership.
- Candy, B., Holman, A., Leurent, B., Davis, S. and Jones, L. (2011) Hospice care delivered at home, in nursing homes and in dedicated hospice facilities: a systematic review of quantitative and qualitative evidence, *International Journal of Nursing Studies*, 48(1):121–133.
- Care Quality Commission (2015) Priorities for care part of a new approach to care for dying people. Available at: <http://www.cqc.org.uk/content/priorities-care-part-new-approach-care-dying-people>
- Casarett, D., Crowley, R. Stevenson, C., Xie, S. and Teno, J. (2005) Making Difficult Decisions About Hospice Enrollment: What Do Patients and Families Want to Know? *Journal of the American Geriatrics Society*, 53(2): 249–254
- Casarett, D., Crowley, R. and Hirschman, K. (2004) How Should Clinicians Describe Hospice to Patients and Families? *Journal of the American Geriatrics Society*, 52(11): 1923–1928.
- Chen, H. R. and Cheng, B. (2012) Applying the ISO 9001 process approach and service blueprint to hospital management systems. *Total Quality Management Journal*, 24(5): 418-432.
- Churchman, R., York, G.S., Woodard, B., Wainright, C. and Rau-Foster, M. (2014) Revisiting Perceptions of Quality of Hospice Care: Managing for the Ultimate Referral, *American Journal of Hospice and Palliative Medicine*, 31(5):521–526.
- Coenen, C., von Felten, D., and Schmid, M. (2011) Managing effectiveness and efficiency through FM blueprinting. *Facilities*, 29(9): 422-436.
- Department of Health (2009) Understanding what matters: a guide to using patient feedback to transform services. Available at: http://www.nhssurveys.org/Filestore/documents/DH_Understanding_what_matters.pdf

Department of Health (2013) Health and Care System, April 2013. Available at: <https://www.gov.uk/government/publications/the-health-and-care-system-explained/the-health-and-care-system-explained>

De Roo, M. L., Leemans, K., Claessen, S. J., Cohen, J., Pasman, H. R. W., Deliens, L. (2013) Quality indicators for palliative care: update of a systematic review. *Journal of pain and symptom management*, 46(4):556-572.

Dy, S. M., Kiley, K. B., Ast, K., Lupu, D., Norton, S. A., McMillan, S. C., Herr, K., Rotella, J. D. and Casarett, D. J. (2015) Measuring What Matters: Top-Ranked Quality Indicators for Hospice and Palliative Care From the American Academy of Hospice and Palliative Medicine and Hospice and Palliative Nurses Association, *Journal of Pain & Symptom Management*, 49(4):773–781.

Evans, C. J., Benalia, H., Preston, N. J., Grande, G., Gysels, M., Short, V., Daveson, B. A., Bausewein, C., Todd, C. and Higginson, I. J. (2013) The Selection and Use of Outcome Measures in Palliative and End-of-Life Care Research: The MORECare International Consensus Workshop, *Journal of Pain and Symptom Management*, 46(6): 925–937.

Gysels, M., Evans, C. and Higginson, I. (2012) Patient, caregiver, health professional and researcher views and experiences of participating in research at the end-of-life: a critical interpretive synthesis of the literature, *BMC Medical Research Methodology*, 12: 123-140.

Hospice UK (2015) Facts and Figures: key facts and statistics about hospice care. Available at: <http://www.hospiceuk.org/media-centre/facts-and-figures>

Kostopoulos, G., Gounaris, S. and Boukis, A. (2012) Service blueprinting effectiveness: drivers of success, *Managing Service Quality: An International Journal*, 22(6): 580 – 591.

Myers, G. E. (2002) Can illness narratives contribute to the delay of hospice admission? *American Journal of Hospice & Palliative Care*, 19:325–330.

NHS Confederation (2010). Feeling better? Improving patient experience in hospital. Available at: http://www.nhsconfed.org/~media/Confederation/Files/Publications/Documents/Feeling_better_improving_patient_experience_in_hospital_Report.pdf

NHS National Quality Board, (2015). Improving experiences of care: Our shared understanding and ambition. Available at: <https://www.england.nhs.uk/wp-content/uploads/2015/01/improving-experiences-of-care.pdf>

Pasman, H. R. W., Brandt, H. E., Deliens, L. and Francke, A. L. (2009) Quality Indicators for Palliative Care: A Systematic Review, *Journal of Pain and Symptom Management*, 38(1): 145–156.

Picker Institute Europe (2009) Using patient feedback. A practical guide to improving patient experience. Picker Institute Europe. Available at: www.pickereurope.org

Polonsky, M. J. and Garma, R. (2006). Service blueprinting: A potential tool for improving cause-donor exchanges. *Journal of Non-profit & Public Sector Marketing*, 16(1-2):1-20.

Schenck, A. P., Rokoske, F. S., Durham, D. D., Cagle, J. G., & Hanson, L. C. (2010) The PEACE Project: identification of quality measures for hospice and palliative care. *Journal of palliative medicine*, 13(12): 1451-1459.

Simon, S.T., Higginson, I.J., Harding, R., Daveson, B.A., Gysels, M., Deliens, L., et al. (2012) Enhancing patient-reported outcome measurement in research and practice of palliative and end-of-life care. *Support Care Cancer*, 20(7): 1573-1578.

Shostack, G.L. (1987) Service Positioning Through Structural Change, *Journal of Marketing*, 51:34-43.

Sulmasy, D.P., McIlvane, J.M., Pasley, P.M., Rahn, M. (2002) A scale for measuring patient perceptions of the quality of end-of-life care and satisfaction with treatment: the reliability and validity of QUEST. *Journal of Pain Symptom Management*; 23(6): 458- 470.

Teno, J. M., Casey, V. A., Welch, L. C. and Edgman-Levitan, S. (2001) Patient-Focused, Family-Centered End-of-Life Medical Care: Views of the Guidelines and Bereaved Family Members, *Journal of Pain and Symptom Management*, 22(3): 738–751.

The Health Foundation (2013) Measuring Patient Experience. Available at:
<http://www.health.org.uk/publication/measuring-patient-experience>

Waldrop, D. P. and Rinfrette, E. S. (2009) Making the Transition to Hospice: Exploring Hospice Professionals' Perspectives, *Death Studies*, 33(6):557–580.

Wallace, C., L. (2015) Family communication and decision making at the end of life: A literature review, *Palliative & Supportive Care*, 13(3): 815–825.

WHO (2015). WHO Definition of Palliative Care. Available at:
<http://www.who.int/cancer/palliative/definition/en/>

Zeithaml, V., Bitner, M .J. and Gremler, D. (2006), *Services Marketing – Integrating Customer Focus across the Firm*, 4th ed., McGraw-Hill, New York, NY.