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A foundation trust developed a patient experience vision that engaged staff in creating a healthcare model for the future

A vision of the future for patient experience

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In 2010, Liverpool Heart and Chest Hospital Trust (LHCH) had been rated top for “overall care” in the national inpatient survey for three consecutive years. However, the executive nurse and CEO knew there was room for improvement and wanted to understand how we could do better.

The executive team believed that if we could create a vision of the future with which employees could identify, staff engagement and effort could be improved. The vision developed was centred on patient experience, but relied on staff understanding that they had “permission to act” to ensure everyday practice and care given by every member of staff were consistent with the vision.

Process
We began by reviewing the evidence and work by other health organisations in the UK and internationally. We found that organisational culture had the greatest influence on patient experience, and realised that staff would need something to keep them motivated, particularly since the NHS was experiencing difficult financial times.

The patient experience vision (PEV) was developed. It was told as the story of a patient using LHCH in three years’ time – it described the “perfect patient experience” (summarised in Box 1).

We recognised that the story needed to be in a format with which staff could easily identify and that we needed to be able to measure its success. To do this, we developed the Six Steps of Our Patient Experience Vision (Fig 1), with extensive staff engagement. Staff were asked to vote on the title of each step, the pictures and statements. This was a good opportunity to communicate the vision and spark staff interest.

Our ambition was that by 2013 everyone who used our services agreed with each of the six steps. We measured levels of...
agreement, as well as other matters (Fig 1).

During the first year of the PEV, much time was invested in helping staff to understand their contribution to delivering the vision. It was incorporated into personal development reviews (PDRs) and other areas, such as staff awards.

**Key successes**
The main successes of the PEV are both big and small. Collectively, they have made a significant difference.

» We introduced “majoring on the minor”, a concept based on the seemingly small things that often matter to patients and families. For example, staff in the theatre waiting area realised that patients were often cold from being fasted and nervous about having major surgery, so they invested in a blanket warmer so they could offer patients warm, soft blankets. Family members are now invited to accompany patients to the waiting area. Staff say the PEV refocused their attention and gave them “permission” to make changes, which is the cultural shift we were seeking.

» We introduced patient and family engagement events four times a year, and used feedback from these to make system and environmental changes. For example, after several patients who had undergone cardiac surgery told us that the water pressure from the showers was too powerful on their chest wound, estates sourced an alternative, adjustable and cheaper showerhead.

» The board agreed two major capital schemes in 2011, to build a new day unit and inpatient ward. Both were designed jointly with families, patients and staff, with dedicated space for family and staff, and facilities in 12 single rooms so

**BOX 1. CASE STUDY: A VISION FOR PATIENT EXPERIENCE**

After booking online and receiving a welcome pack, Mr Smith arrives for his first appointment. Parking is easy and signs are colour coded. He is welcomed at the outpatients’ department and already notices that it “doesn’t really feel like a hospital”.

After a series of tests, which happen on one day and run to time, he and his wife meet the consultant and a nurse, Helen, who says she will stay during the consultation so she can explain any further details or information they require later.

The consultant takes time to explain what is wrong, using a diagram to pinpoint the problem. The treatment offered is based on the best evidence available and has been individually considered to take into account any specific problems Mr Smith has.

When they have finished, Helen escorts them to a room where they have a drink while she explains the next steps. He is comforted that Helen is his assigned support nurse and can be contacted with any questions and will support him after his procedure.

Helen gives him a patient contract which details what will happen each day during his stay, from mealtimes to when he can expect to be discharged, as well as what he can expect from hospital staff, including attitude, handwashing, name badges and who to speak to if the service falls short.

Over the next two weeks, Mr Smith phones Helen twice. He and his wife tell friends it is like having their own personal nurse and nothing is too much trouble.

On the day of his intervention, Helen greets him in the admissions lounge. His wife comments on how relaxed the lounge feels as all the patients are met by their support nurses.

At Tlam Helen and Mr Smith’s wife escort him to the theatre and Helen gives them a few moments together. Helen then takes Mrs Smith to the visitors’ lounge where she can have a drink and a snack before going home. Telephone calls through the day help alleviate her anxiety.

Three days after admission, Mr Smith is progressing well. He tells his wife the staff are fantastic, the healthcare team visit him every day to ensure that he is on track with the goals in his patient contract and his consultant is pleased with his progress.

The ward is designed so he can clearly see how far he needs to walk as part of his rehabilitation. The environment feels more like a hotel; it is clean and tidy, he can choose his meals just before they are delivered and watch his favourite TV programme. A volunteer arrives each morning to take orders for newspapers and magazines and have a chat.

Mr Smith is a little nervous on the day of discharge, but the hospital team make him feel safe. The pharmacist has explained his new medication and the ward manager has discussed his follow-up appointment. All these details are written on his patient contract. Helen will call him in two days to check how he is progressing and he knows he can call her and the team if he has any questions or concerns.

On their way home, Mr and Mrs Smith agree they have had an outstanding experience at Liverpool Heart and Chest Hospital.
family members could stay overnight. Other areas embarked on a programme introduced by the King’s Fund. “Enhancing the Healing Environment” involved upgrading the decor, furniture and lighting, which were also designed jointly with staff, patients and families. Some of the key changes have been within our 40-bed critical care unit. We relaxed visiting times so families can come and go as they please; previously, visiting was restricted and family members were generally invited in after care had been delivered.

As the PEV became embedded, we started to introduce the concept of patient and family-centred care (PFCC). This was consistent with our patient-centred care approach, but also recognised the importance of family within the model of care.

Measuring outcomes
A series of qualitative and quantitative measures were developed to identify progress. These were cascaded through the organisation to ward and department level in conjunction with staff so they could choose their priority areas. This two-way approach was essential to keep staff engaged.

By May 2012, LHCH had retained the position of top in the country for overall care, with an increased score year on year. We had also moved from being in the bottom 20% for staff satisfaction to the top 20%. This was viewed as a key success and essential for sustainability.

The CQC performed an unannounced inspection in early 2012 and commented on how keen staff were to talk about the PEV and what it had done for them. They also gave us a clean bill of health against five of the essential standards for quality and safety.

We use the vision to guide most of what happens at the trust. For example, staff performance is measured by their contribution to the vision and it guides where we invest in our estate. The board uses an innovative set of metrics to monitor progress; these are quantitative (Fig 2) and qualitative, such as themed patient feedback. Staff report that the six steps of the patient vision have brought in a common language that unites all teams and professions.

Plans
The PFCC approach is increasing across the NHS, driven by: a body of evidence; organisations such as the Picker Institute, the Enhanced Recovery Programme and IHI Improving Care at the Bedside; and patient voices. Moving to PFCC from patient-centred and patient-focused care requires a culture change.

LHCH has now developed the next three-year stage of our patient experience model; PFCC will be at its core – a first for acute hospitals in the country.

Signs are being improved across the trust and we have a project to improve the environment throughout the hospital, focusing on everything from new staircase railings to artwork on the walls.

Patient and family shadowing will be embedded over the next three years, allowing staff to gain insight into patients’ and families’ experiences.

We are examining the model of care delivery used on our wards and the concept of families as care partners. By involving relatives in helping with giving meals, drinks and medication and being involved in therapy sessions, we hope to formalise the role of relatives as care partners. We also understand that some family members may choose not to be involved in care, but our aim is to give them the choice.

To complement these changes, we aim to deliver patient- and family-centred ward rounds, which we believe are fundamental to embedding PFCC across the trust. In April 2013, the trust hosted the first UK conference on patient- and family-centred care.

Conclusion
Our vision has been successful in improving patient experience. We believe this is largely due to staff engaging with it and making it an intrinsic part of the way they work. Giving relatives greater involvement in care also enhanced the experience patients have when admitted to our trust.

References