Evaluating the patient journey approach to ensure health care is centred on patients

An action-research study examines a patient journey model to improve patient-centred care and the collaboration needed for the project’s success.

**INTRODUCTION**
A directive in *The NHS Plan* advocated that ‘the NHS must be redesigned to be patient centred – to offer a personalised service’ (Department of Health, 2000). This initiative comprised a six-month multidisciplinary service improvement/practice development model.

Campbell et al (2004), from the City Hospitals Sunderland NHS Foundation Trust (CHS), designed their ‘patient journey’ model in response to this modernisation programme.

If it was to become more patient centred, the trust believed that ‘the insider perspective of the illness experience’ (Thorne and Paterson, 2000) and patients’ views and experiences should be taken into account as a fundamental part of service redesign.

The CHS created its patient journey approach from aspects of the integrated care pathway process, but with a greater emphasis on patient involvement and partnership.

It recommended that project team membership should be drawn from the broad range of disciplines linked to patients’ healthcare journeys.

The CHS described its patient journey as ‘a dynamic, locally agreed, patient-centred process, which crosses organisational and primary/secondary care boundaries. The pathway is developed by the multidisciplinary team, which includes strong patient/carer involvement, using the best evidence to guide practice’ (Campbell et al, 2004).

By 2005, the trust had piloted more than 20 patient journeys and completed 16 in the patient groups shown in Box 1.

Campbell et al (2004) said the approach was ‘explicit, different and making a difference to patients’. However, at that time, no formal or independent evaluation of its effectiveness had been carried out.

**LITERATURE REVIEW**
The vision of high-quality, patient-centred, evidence-based health care has been at the heart of NHS reforms for many years.

Numerous government directives all argue that the NHS must deliver high-quality, safe and personalised, patient (person)-centred health care (DH, 2007; 2005; 2004; 2000).

Yet, even now, in spite of ever-increasing emphasis on providing personalised NHS health care, and numerous frameworks and models to enable its delivery, excellence in patient-centred health care continues to evade many areas of the NHS.

Evidence to support this view is readily available from the media (BBC News, 2008; Open2.net, 2007), the literature, or through personal observation or experience.

It could be argued that one reason for this is that many of these initiatives still appear to fail to reach or include frontline staff.

Of the projects that do include practitioners...
– such as integrated care pathways and the Productive Ward initiative (NHS Institute for Innovation and Improvement, 2007) – none appears to include feedback from patient interviews in service redesign.

Neither do they seem to draw from membership of the broad range of disciplines linked to patients’ healthcare journeys.

Furthermore, it could be argued that trying to improve healthcare services without learning more about patients’ experiences or asking what they really want may explain why excellence in patient-centred care delivery still eludes many areas of the NHS.

Providing personalised health care is a complex, diverse and multi-faceted issue. It is influenced by many factors, on both the actual delivery of health care and patients’ expectations and perceptions of their experiences.

In light of this, it could be argued that it is imperative to take into account both patients’ and healthcare providers’ views if the NHS is to fulfil its vision of personalised, patient-centred health care.

Goodrich and Cornwell (2008), Richards and Coulter (2007), Scott and Caress (2005) and Wales (2005) supported this view. They recognised that patient-centred care requires effective interprofessional relationships based on shared visions and a clear understanding of patients’ needs and their individual perspectives.

Furthermore, Bauman et al (2003) argued that efficient, effective collaboration between NHS management and healthcare professionals was vital in achieving excellence in health care. Campbell et al (2004) said these factors were central to the CHS patient journey approach.

Interestingly, despite the government’s focus on the NHS becoming patient centred and offering a personalised service (DH, 2000), the government has not provided a single, succinct definition of ‘patient centred’.

This is surprising, given there are over 1.2 million staff across more than 600 NHS trusts who are expected to provide patient-centred services to the millions of people needing health care every year (NHS Choices, 2009).

In view of this and to avoid confusion, the term ‘patient-centred’, in the context of this study, refers to health care that fulfils the individual needs and expectations of the whole person, rather than merely the ‘patient’.

This review also highlighted that there were different interpretations and uses of the term ‘patient journey’. These were most commonly associated with a person’s health trajectory or the process of mapping the patient’s journey through healthcare organisations.

In the context of this study, the term ‘patient journey’ refers to a process. This is a practice development/service improvement model that incorporates the patient’s journey, the individual’s lived experience and views of healthcare professionals.

**AIM**

Although CHS had piloted more than 20 patient journeys, in 2005 no independent or written evaluation of the model existed.

Furthermore, all these projects had been run or overseen by team members who had been involved in developing the patient journey approach, understood the process, and were employed by and held positions of authority within CHS.

The main aim of this qualitative, action-research study was for an ‘outsider’ – a newly qualified nurse with personal experiences as a patient – to this approach and the trust to implement a new patient journey.

This was carried out in an unaffiliated NHS hospital trust in the South West of England, to enable the approach to be independently and impartially tested and evaluated.

**METHOD**

Action research was chosen for this study because of its natural affinity with the anticipated cyclical and constantly evolving nature of the CHS patient journey model (Campbell et al, 2004).

This research method involves a qualitative, collaborative approach (Coghlan and Brannick, 2001).

The trust recommends that each patient journey should be conducted as an individual research project and, as such, must meet NHS research governance procedures.

Full ethical and research and development approval was obtained before implementing the new patient journey.

The active phase of the project ran from May to December 2007, during which time monthly project team meetings were held.

The activities set out in Box 2 were carried out in accordance with the CHS patient journey model.

**Recruiting the multidisciplinary project team**

The vascular patient journey project team was set up.

The team comprised the following: vascular consultants; consultants specialising in the care of older patients; anaesthetists; director of nursing; service improvement managers; nurse practitioner; matron; practice development lead nurse; divisional general manager (surgery); general manager (surgery); vascular specialist nurse; clinical nurse specialist (primary care); ward sisters; occupational therapists; physiotherapist; pharmacist; superintendent radiographer; medical secretaries; senior social worker; and waiting list coordinator.

Key roles were agreed at the first meeting, in accordance with the CHS patient journey model:

- Vascular patient journey chair – director of nursing

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**BOX 1. PATIENT GROUPS FOR JOURNEYS**

- Acute coronary syndrome
- Prostate cancer
- Cholecystectomy
- Laryngectomy
- Acute myocardial infarction
- COPD
- Acute child admissions
- Ovarian cancer
- Lung cancer – two journeys
- Percutaneous endoscopic gastrostomy (PEG)
- Head injury
- Stroke
- Epilepsy
- Strabismus
- Fertility

**BOX 2. ACTIVITIES FOR PATIENT JOURNEY MODEL**

- Recruiting multidisciplinary project team – key roles assigned
- Matrix sampling
- Process mapping
- Interviews with patients
- Identifying issues and solutions (based on feedback from interviews and mapping)
- Action planning/proposals for service improvement

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Clinical champion – vascular consultant surgeon;
Local facilitator – nurse practitioner;
Patient journey facilitator – researcher.

Matrix sampling
The vascular patient journey project team used matrix sampling, which is similar to purposive or stakeholder sampling, as recommended by CHS (Campbell et al, 2004).

The method enabled the team to determine and agree which criteria would facilitate the selection of patients who best represented their sample group.

In this instance, they were identified as patients with peripheral vascular disease who had undergone surgery for a femoral bypass graft in the previous six months. From a list of 25 eligible patients, 11 participants were finally recruited for interview.

Process mapping
Three process mapping sessions were held between June and late August 2007 and run by a service improvement manager with expertise in this area.

The patients’ journeys, for elective and emergency admissions, were mapped from the point of referral/admission through to 1–2 days post surgery. This is a lengthy process because of this group’s complex needs.

The information was transferred onto a flow chart, with each step on the chart numbered and accompanied by explanatory notes.

The final map (flow chart) of the patient journey was produced after consultation and agreement with the project team.

Semi-structured interviews with patients and relatives/carers
Participants were aged 45–80 years, and there were six men and five women. Six participants had a spouse/partner/relative present.

All gave written, informed consent before the interviews, which took place in their homes between August and November 2007.

The informal interviews started with the patients’ journeys, for elective and emergency admissions, being mapped from the point of referral/admission through to 1–2 days post surgery. This is a lengthy process because of this group’s complex needs.

The information was transferred onto a flow chart, with each step on the chart numbered and accompanied by explanatory notes.

The final map (flow chart) of the patient journey was produced after consultation and agreement with the project team.

Identifying issues and solutions from the research
Issues for action were identified from both the patient interview feedback and the mapping exercises.

These were amalgamated into an issues and solutions document, which contained 75 issues for further discussion and prioritisation by the project team.

Action planning/proposals for service improvement
After prioritising the issues that had emerged from the research and discussing possible solutions, the project team jointly agreed and assigned actions to be taken.

The issues ranged in complexity from ensuring that skimmed milk was available for patients on the wards to purchasing diagnostic imaging equipment.

RESULTS
The most powerful element of the patient journey process was undoubtedly the feedback gathered from patients and carers during the interviews.

The project team commented on how much they had valued learning about the actual experiences and views of their patients.

Furthermore, they acknowledged that, had this information been collected by more traditional means such as surveys or questionnaires, the data would not have been so detailed and informative, and was unlikely to have created the same impact.

For instance, overall participants spoke extremely highly of the care they received. Comments included: ‘Swiftness at admission was amazing’ and ‘Care in hospital was fantastic’. They were keen to express their gratitude to staff: ‘They’ve all done a good job... excellent’ and ‘She’s wonderful’.

Had these views on health care been collected by a more structured method, it could have been possible that patients’ responses might have yielded ‘satisfied’ or ‘very satisfied’ results only.

It was only as the interviews progressed that the deeper, more insightful and sometimes distressing information was revealed, as shown by the examples in Box 3.

The vascular patient journey project team placed a high value on learning about these experiences, being aware of strengths and weaknesses in service delivery and having the opportunity to discuss, review and jointly plan the way ahead.

Many team members reported how working in this way – and especially learning more about their patients’ experiences and expectations – had not only ‘opened their eyes’.
but also ‘broadened their thinking’.
They observed how this increased awareness was likely to have a positive influence on their future practice.

### Outcomes

The following are examples of some of the results achieved in response to the issues identified during this patient journey project:

- Inter-hospital access to IT diagnostic imaging results is now possible for consultants;
- The short-notice surgical admission notification procedure was changed – vascular patients are now only contacted by medical staff/nurse practitioners for short-notice admissions;
- A dedicated telephone line/answer phone was installed, giving patients direct contact to the vascular nurse practitioner;
- Angioplasties became available as day-case procedures for suitable patients from January 2008 in an attempt to reduce delays;
- Clearer information and guidelines on medications before hospital admission for surgery are now available for patients, in a revised patient information sheet on this topic;
- Pre-operative medication and fasting procedures were clarified in a revised nil-by-mouth policy and distributed to staff;
- Skimmed milk is available on wards on request;
- Patient information leaflets for surgical patients are being reviewed, after a patient requested information on the possible psychological/emotional effects following anaesthesia/surgery;
- Funding has been obtained for a portable head for the duplex scanner (the results of a further bid for an extra duplex scanner are awaited).

### DISCUSSION

Despite a number of setbacks before and during the project, these examples show how the patient journey process can be an effective, patient-centred, collaborative service improvement model that can yield varied and tangible results.

The model also enhances the knowledge, understanding and interprofessional working practices of those involved.

The approach may be adapted for specific patient groups diagnosed with acute or long-term conditions – or both, as in this example.

The learning from a project such as this is invaluable and extends far beyond that which can be described in this article.

Perhaps the strongest aspect of this approach is the opportunity to hear the patient’s voice, to really learn about their experiences and expectations.

This is information which, had it been gathered through more traditional forms such as questionnaires or surveys, might have yielded results indicating only that these patients and their partners/carers/families were satisfied or very satisfied with their health care.

If the government’s vision of the health service becoming patient centred is to be realised, it is extremely important that both service users’ and service providers’ views are taken into account.

In addition, it is vital to give interprofessional working the opportunity to flourish.

### REFERENCES


NHS Institute for Innovation and Improvement (2007) Releasing Time to Care: the Productive Ward. tinyurl.com/productiveward


