Designing experience

Author: 'Prospector'

OVERVIEW

The report of the Future Hospital Commission of the Royal College of Physicians acknowledges that the principal challenge for health care organisations and professionals responsible for delivering medical services is to accept the fundamental requirement that patients must be treated with compassion, kindness and respect while having their physical and emotional needs met at all times. The recognition that clinical outcomes alone are an insufficient guide to the adequacy of health service provision demands cultural, organisational and individual change. In the Forum of the Future Hospital Journal we will try to scan the world literature for papers that can cast light upon the systems of care that might best ensure these principles are delivered, wherever they have been developed, and to critically evaluate their potential impact. The theme in this edition is patient experience.

Prospector was left nonplussed at the outset of his intellectual stroll through the contents of this issue of the Journal. While there is a body of academic literature describing the architecture and building design of hospitals, discussion is in the main confined to journals that might politely be described as 'niche', with titles such as *Health Estate Journal*, *Health Facilities Management* and *Health Environments Research & Design*. At first glance they contain papers at least of relevance to the theme under consideration, but whether they can hold the attention of the impatient 'Future Hospitalist' is a matter of conjecture.

Recent publications record and analyse interesting correspondence between Florence Nightingale and architect Thomas Worthington, and refer to the thinking of Isambard Kingdom Brunel during the development of the first 'modern' hospitals designed to improve clinical outcomes and patient comfort in the 19th century.[1,2] By comparison, those showing that hospital design may reduce infection and comfort patients with delirium, Alzheimer's disease or terminal illness, offer new solutions to old problems.[3–6] One review summarised in the *Lancet*, but available online, comprehensively describes how evidence-based hospital design can 'reduce staff stress and… increase effectiveness in delivering care and patient safety, reduce patient and family stress and improve outcomes and overall healthcare quality'.[7,8] *Prospector* reflects that all of these papers describe the importance of the environment to the quality of care which patients receive. 'Experience design', the term employed to describe the practice of allowing the eventual user's experience of the proposed environment to inform the design itself, is a well-accepted concept in architecture. Its corollary in medicine, the 'patient experience', is relatively novel as a measurable health outcome and its utility is debated. However, the Future Hospital Commission (FHC) report noted that the second core principle around which 'hospital services in the future should be designed' is that the 'patient experience is valued as much as clinical effectiveness'.[9] Why is this and how should those at the clinical coalface, educated almost exclusively to focus on clinical effectiveness, respond?

It seems unnecessary to point out that while patients have had an 'experience' of healthcare for as long as medicine has been practised, the medical establishment has begun to concern itself with and value this concept only in the past two or so decades. In fact, Berwick *et al* suggest that improving patient experience should be one of the three essential foci of a health care system (the others being population health and per capita cost).[10] An understanding that paternalism is an outdated model of health provision[11] and that care should be patient-centred leads *Prospector* to conclude that assessments of patient experience represent fundamentally important independent healthcare outcome measures. To his surprise, there are those who disagree.[12] In the United States there is an ongoing debate, particularly regarding surgical patients, about the relevance and validity of patient experience as an outcome measure. Several recent attempts to link patient experience to other quality indicators have shown both positive and negative correlations; in one counterintuitive instance, better patient experience was linked to increased mortality![13–17] *Prospector* finds himself agreeing with those that contend that 'the lack of a relationship reflects the different dimensions of care captured by each, with morbidity and mortality measuring more traditional dimensions of safety and effectiveness and [patient experience questionnaires] capturing patient-centeredness, timeliness, and efficiency'.[18] Further, he notes with amusement the conclusion of one of the studies 'that factors outside of surgical outcomes appear to influence patients' perceptions of their care'; sounds like an epiphany. In part, resistance to the utilisation of patient experience measures is linked to fears that pay for performance will disadvantage some physicians who are, for instance, caring for dying patients or drug addicts, and perversely incentivise harmful healthcare behaviours such as the unnecessary prescription of opiate medication.[19] Such concerns do not invalidate patient experience measures *per se*, but rather argue for their standardisation and adjustment for specific diseases and patient populations.[20] Certainly in the UK, when GP payment was directly linked to patient experience, there was a notable improvement in several quality measures.[21]

This was not sustained when funding was withdrawn and some are calling for further, similar incentivisation.[22]

With or without such motivation, how should doctors working in the Future Hospital approach the challenges of measuring patients' experience of their care? In order to answer this question the reader should first, be reminded of the guidance from the National Institute for Health and Care Excellence – *Patient experience in adult NHS services: improving the experience of care for people using adult NHS services* – which offers detailed advice in this regard.[23] Second, *Prospector* will introduce this edition's battle cry (and required reading) that the collection of such data has not persuaded healthcare providers to systematically improve their services. Coulter *et al*[24] describe the variety of national patient experience surveys ongoing in the UK[25] (www.nhssurveys.org) and the advantages and disadvantages of the different methodologies used. After noting that the collection of such data has failed to lead to sustained improvement in outcomes, the authors argue for a strategic and coordinated national response, concluding 'It is unethical to ask patients to comment on their experiences if these comments are going to be ignored'. Indeed.

The proliferation of papers detailing the patient experience of a multitude of diverse interventions, from rhinoplasty to hip replacement, the presence of medical students or physiotherapists or the use of electronic patient records, all suggest a growing willingness by healthcare professionals to engage with, and to understand these experiences as unique and important outcomes.

Nevertheless, *Prospector* agrees with Coulter *et al* that assessment alone is not enough. Perhaps there is a danger that measuring experience, rather as in the case of audit in days past, becomes an end in itself rather than a driver for continual change and improvement. No doubt a national response is needed, but to conclude this Forum, *Prospector* draws your attention to a smaller scale case study which was published in the report of the FHC; in his opinion, it represents an important guide for those seeking to deliver quality improvement.[26] Northumbria Healthcare Trust, deemed to 'consistently deliver a good patient experience', has established a range of interventions aimed at promoting patient-centred care. While the Trust relies on national surveys to benchmark its data, more emphasis has been placed on the individual performance of staff and wards. While a 'Two minutes of your time' exit survey is used to answer the friends and family question on discharge, feedback from 20,000 patients every year is independently provided by Patient Perspective, a private contractor. Surveys are sent out in the two weeks after discharge, when patients are statistically at their least satisfied[27] and, outside of the hospital environment, more free to say why. An important feature of the programme is that data are collected continuously and real-time results are available to all staff, wards and patients, on the public hospital intranet and on scorecards displayed on each ward. All consultant staff are ranked according to their patient experience surveys, and individuals are told what their patients have said about them, good performance being celebrated publically. Wards or services falling below thresholds in key domains are expected to review patient feedback and use this to consider changes and improve. Such transparency must seem alarming at first to those not used to such scrutiny but surely it is time for us all to look into the mirror of patient experience in this way and to ask ourselves whether we like what we see. ■

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