




Learning and leading in the experience age

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Learning and leading in the experience age

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Abstract

A focus on experiences of care helps health systems realize the very transformations they look to achieve. This is because patient experience allows patients, families and carers to define value, enabling healthcare organizations to focus on what matters to them and not simply what is the matter with them. This is what we mean by an 'experience age', one in which clear connections are made between the things patients value and the clinical outcomes we look to achieve: where links are drawn between experience, clinical effectiveness, safety and cost in order to provide the very best care for all patients. Central to the experience age is ensuring our health systems: (1) are accountable for the whole patient experience and thus able to act sooner to keep people well and out of hospital, (2) work to establish new relationships with patients, families and carers in which patients, carers and staff work together to establish what matters and how care can be delivered and (3) make stronger connections between patient and staff experience. In committing to these efforts, the global dialogue on patient experience will become even more important, as we recognise that despite differences in design and operation, the challenges our health systems face and the focus on what matters most to patients are shared.

Keywords

Patient experience, patient experience improvement, experience age, health equity, global healthcare, patient, family and carer engagement, staff engagement

The Experience Age

Although there are unique factors to every health system, almost all are facing growing pressures from rising demand, ageing populations and the adoption of new medical technologies. In that context, it is encouraging that despite these pressures, patients are reporting that experiences of care are being maintained and even improved. I have been particularly pleased to see improvement in the numbers reporting that they are treated with dignity and respect. In England, this reflects the recognition we have given in recent years to compassionate, person-centred care and the investment we have made in listening to patients, families and carers. In addition to national surveys, which allow us to make comparisons between trusts, 12 million people every year now complete real-time feedback about their experiences of individual services, which allow clinicians to do more of what works and make improvements where they are needed.

From a national perspective, the renewed focus on experiences of care will also help health systems achieve the transformations we need over the next few years, as we implement our vision for the NHS in England. This is because patient experience allows patients, families and carers to define value, enabling us to focus on what matters to them and not simply what is the matter with them and get care right first time.

In cancer, for example, we are introducing a new faster diagnosis standard, which means that by 2020, all patients will receive a definitive diagnosis of cancer or have cancer ruled out within 28 days of an initial referral. Not only will this improve patient experience but it will also facilitate the earlier treatment which saves lives. This, for me, is what we mean by an 'experience age' in our health service, one in which clear connections are made between the things patients value and the clinical outcomes we achieve: where links are drawn between experience, clinical effectiveness, safety and cost in order to provide the very best care for all our patients.

The ambition to achieve high quality care for all is critical, as there are some patients who have received poorer care historically and it is vital that we measure our success by the transformation we can achieve for them too.

For example, a third of deaths of people with Learning Disabilities might be avoided with healthcare interventions, often linked to earlier diagnosis and treatment of a small number of conditions like epilepsy. We have recently made it a requirement for hospitals to review the death of all patients with a Learning Disability, so that lessons can be learned. In addition, we will ensure that people with a Learning Disability and their families themselves have a much stronger voice in how we measure the quality of care, by introducing Quality Checker services across the NHS. It is obvious that we will not be able to reduce premature mortality significantly

without improving the experiences people have of mainstream NHS services, like urgent and emergency care. In our experience age, as quality improves for all patients, it must improve at least as much for the most vulnerable.

Three Critical Commitments

Such ambitions require further change as well as renewed commitment and there are three developments that will underpin our success.

First of all, it is no longer enough to run world-class hospitals. Experience is often poorest at the boundaries between care, whether that is between physical and mental health, general practice and hospital care or child and adult services. We need health systems that are accountable for the whole patient experience and thus able to act sooner to keep people well and out of hospital. We are now seeing the first Accountable Care Systems come into place in England, which will provide us with an exciting opportunity to improve the co-ordination of care and push it upstream as far as possible, to the benefit of both experience and outcomes.

Secondly, we need a new relationship with patients, families and carers. Traditional models of consultation have not consistently delivered services designed around what patients most value. Instead, we need to see through our rhetoric of co-production, in which patients, carers and staff work together to establish what matters and how care can be delivered. As we have adopted 'always events' into the NHS, we have found that genuine partnership between patients and staff helps identify simple yet powerful improvements that genuinely matter to patients and earn the commitment of staff. This needs to become part of business as usual.

Finally, we need to make stronger connections between patient and staff experience. Although we understand that staff experience is the best predictor of patient experience, we have not yet done enough to integrate these two agendas and they can be pursued in silos. Programmes designed to improve both dimensions of experience can not only improve quality of care but can also save money, by reducing stress levels and staff sickness, which are too high in many health systems around the world. Staff are the patient experience and how we treat them matters to patients.

As we enter this experience age and seek to learn from the journey we have taken, the global dialogue on patient experience will become even more important, as we recognise that despite differences in design and operation, the challenges our health systems face and the focus on what matters most to patients are shared. The connections that were made in March this year with Jason Wolf contributing by video to my Chief Nursing Officer Summit, a video link between The Beryl Institute Patient Experience Conference in Denver and an NHS event in England are just the kind of exchange we will need more of in future. We have so much to learn from each other.