

02 | BITE-SIZE GUIDE TO PATIENT INSIGHT:

INSIGHT – WHAT IS ALREADY AVAILABLE?

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Any service needs to understand the people it serves. Without this understanding we have less chance of delivering care that is safe, effective and that is experienced positively.

To help us achieve this we need insight into the needs, experiences and outcomes of the patients who use our services and of the staff who deliver them.

Our work with commissioners and other users of this type of information, has shown that not everyone is aware of what already exists in this field. There is a great deal of information being collected already that can be used before procuring something new or that can be used to ensure any new research is based on what we already know. This guide provides an overview of the different types of information already available and brief explanations of how they can be used.

Quantitative and qualitative insight

There are two ways in which insight and feedback can be broadly categorised: qualitative and quantitative work. They provide different insights and are best when used together.

Qualitative

Qualitative research tends to be more exploratory in nature than quantitative research (see below). It is used to gain understanding of underlying reasons, opinions and motivations. It provides answers to questions such as what does dignity and respect mean to people, why did they use that service and not another and what might work better for our users. It tends to be far less structured in form than quantitative

information using open-ended questions and allows the respondent(s) to guide the process as much as the interviewer.

Some common methods include focus groups, in-depth interviews, deliberative events and observational work.

Quantitative

Quantitative research, as the name suggests, quantifies a problem by generating numbers. Quantitative data, often informed by qualitative data, can answer questions such as how many, how often, who and where.

It is used to quantify attitudes, opinions, experiences, behaviours and other defined variables. For example, we can learn how many people had a good patient experience, were treated with dignity and respect or were involved in decision-making.

Quantitative data is usually collected through surveys asking structured questions to a sample of people which, when conducted correctly, can be used to apply the findings to a wider population. When the same survey is conducted in the same way over time it allows us to measure progress, to identify which areas are improving and to evaluate how well something is being delivered. There are a wide range of methods that can be used, each with strengths and weaknesses, including paper surveys, online surveys and telephone interviews.

At a national level there are a large number of national surveys that use quantitative methods.

For each of the surveys, the questionnaires are kept under review, to ensure they reflect current policy and information needs, but always in the context that even small changes can affect the time series. This means that the data is not comparable from year to year.

The national survey programme

Over the last ten years, new national surveys have been introduced on an ad hoc basis and the content and questions asked have gradually evolved. The survey data is used for a range of purposes including regulatory risk monitoring, service improvement and policy decision making. The current national surveys employ different sample sizes, are conducted with differing regularity, and reflect diverse approaches to questionnaire content.

The surveys are designed to:

- ▶ Be nationally representative, as well as representative at commissioner or provider level, so that similar organisations can be compared
- ▶ Enable analysis by specific patient characteristics, such as age or long-term condition, so that we can contrast the experiences of different types of patient
- ▶ Ensure that organisations have robust measurement of their own performance that can be interpreted in more detail through the collection of local insight
- ▶ Track changes in experience over time, to help inform the evaluation of policy
- ▶ Understand where there are aspects of patient experience that are a general cause of concern
- ▶ Identify areas of patient experience where there is wide national variation in the quality of care and understand why
- ▶ Identify organisations that are performing well
- ▶ Identify organisations who may need support in specific areas of health and care

Large scale surveys allow us to measure patient experience and establish differences between groups and areas over time or identify issues for further investigation. Examples at a national level include the

GP Patient Survey and the CQC Adult Inpatient Survey plus a range of other national surveys. These surveys can be supplemented by local surveys that delve deeper into issues that the national survey exposes.

NHS England surveys

GP Patient Survey

The GP Patient Survey (GPPS) is the biggest survey of its kind. It seeks the views of more than two million people every year about their experience of GP practices, services for people with long-term conditions, NHS primary dental care and out-of-hours services.

The results are made available at GP practice and Clinical Commissioning Group (CCG) level at: www.gp-patient.co.uk

Cancer Patient Experience Survey

The Cancer Patient Experience Survey is a postal survey carried out for NHS England, seeking the views of more than 100,000 NHS patients who have been seen for treatment in hospital who had a primary diagnosis of cancer.

The results are available at trust and CCG level at: <http://www.ncpes.co.uk/>

Care Quality Commission surveys

The Care Quality Commission (CQC) uses the results as part of their intelligent monitoring to help to inform inspections. The data provides an invaluable source of information for trusts and CCGs to determine how patient experience is changing over time.

Adult Inpatient Survey

The annual adults Inpatient Survey is a postal survey carried out by the CQC which looks at the experiences of more than 70,000 adults who have received inpatient care.

The data is available at NHS Trust level on CQC's website at: <http://www.cqc.org.uk/>

[cqc.org.uk/publications/surveys/adult-inpatient-survey-2018](http://www.cqc.org.uk/publications/surveys/adult-inpatient-survey-2018)

Children and Young People's Survey

The survey looks at the experiences of children, young people under 16 and their parents and carers attending hospital for treatment as an inpatient or day case. Almost 35,000 of them took part in the 2016 survey.

The data is available at NHS Trust level on CQC's website at: <http://www.cqc.org.uk/publications/surveys/children-young-peoples-survey-2016>

Community Mental Health

The annual Community Mental Health Survey is a postal survey carried out by CQC which looks at the experiences of more than 12,000 people who have received care or treatment for a mental health condition.

The data is available at NHS Trust level on CQC's website at: <http://www.cqc.org.uk/publications/surveys/community-mental-health-survey-2018>

Emergency Department Survey

This survey – called the A&E Survey before its redesign for the 2016 survey – looks at the experiences of around 45,000 people attending a Type 1 or Type 3 urgent and emergency care service provided by an NHS trust during a one-month period. Findings, down to trust level, are published at: www.cqc.org.uk/publications/surveys/emergency-department-survey-2016.

Outpatient Survey

The Outpatient Survey is a postal survey carried out by CQC which looks at the experiences of 72,000 people who have attended an outpatient department. The most recent was in 2011.

The statistics are available down to NHS Trust level on CQC's website at: <http://www.cqc.org.uk/publications/surveys/outpatient-survey-2011>

Maternity Services

The Maternity Services Survey is a postal survey carried out by CQC which looks at the experiences of more than 17,000 women who have

had a live birth in a hospital, birth centre, maternity unit or at home.

The information is available down to NHS Trust level on CQC's website at: <http://www.cqc.org.uk/publications/surveys/maternity-services-survey-2018>

Patient Reported Outcome Measures (PROMs)

PROMs are different in that they do not measure experience but instead ask patients about their outcomes. They assess the quality of care delivered to NHS patients from the patient perspective. The current national PROMs calculate the health gains after hip and knee replacements using pre- and post-operative surveys.

Originally, groin hernia and varicose vein surgeries were also included in the national PROMs programme but a decision was taken to phase out these categories after a consultation.

PROMs allow us to understand the difference that healthcare interventions make to people's quality of life. We can use PROMs to make comparisons across or within providers.

The national results can be found on the NHS Digital (formerly the Health and Social Care Information Centre) website: <http://digital.nhs.uk/proms>

More information about PROMs can be found in our [PROMs bite-sized guide](#).

Understanding survey results

No measurement tool is perfect; when working with any survey results it is useful to bear in mind that there are limitations to what you can read into the data. If you have access to an analyst, they can explain these in detail but, briefly, they are issues such as those listed below.

Patient reported views

The results can only ever represent the subjective views of those responding, so care should be taken to avoid assumptions about the results.

For example, the number of people answering that they have a care plan does not give the actual number of people with care plans; it gives the number of people that report that they have a care plan.

Looking beyond the headline findings

The overall findings can mask issues. For example it is as important to look at the range as it is the mean. Moreover, a high score overall against one survey question may mask that a specific demographic group has a poorer experience, so care should be taken to really interrogate the data.

Confidence intervals

Survey data are based on asking questions of a sample of people, rather than asking the entire population of interest. This means we cannot be completely certain that the result we get is the same as the result we would have found if we had asked the whole population. If the sample of our survey is a random sample, then we can use statistical formulae to calculate a “confidence interval” for our result, which is the range of values in which the true population value lies. For example, we might have a survey result of 82%, but with a confidence interval from 84% (the upper limit) to 79% (the lower limit). This means that we are confident that if we had asked the whole population, then the result would have been between 79% and 84%.

Weighting to reflect population characteristics

The profile of people who respond to a survey is often different to the profile of the population as a whole, usually because some types of people respond in lower numbers than others. For example, younger people tend to be less likely to respond than older people. Survey results are therefore weighted to ensure that each group of people is represented in the right proportion, so that the results are more representative of population as a whole. In some cases both weighted and unweighted data are published, such as on the GP Patient Survey, but we also recommend the use of weighted data as these are more

likely to represent the real state of affairs.

How should commissioners use the national surveys?

Where an issue or problem is identified, survey results can be used to map change over time, assess the impact of new initiatives or to tackle health inequalities. The results can be used to compare and contrast service providers with other similar size and type service providers, the national average, or the top and bottom performers. This can be particularly useful to identify benchmarking partners or to ‘buddy’ organisations that are performing well with organisations looking to improve.

Exploring issues that other organisations, facing similar problems, have successfully tackled may identify transferable solutions and some ‘quick wins’.

National surveys often provide clues as to the extent of a situation - e.g. that 65% of patients report that they were always treated with dignity and respect - and how this compares to this time last year, or to the neighbouring trust. They are most powerful when used in conjunction with other methods, such as those below, to understand ‘why’ people have given the answers they have. Patient feedback can inform commissioning at many stages, particularly when services are under review.

Real time feedback through the Friends and Family Test

FFT is a near real-time feedback tool which is composed of a single question about whether a person would recommend the care that they have had, to others, if it were needed. This question gives us the FFT quantitative results and is followed by an open section, where patients, relatives, carers or visitors can explain their score and give more feedback in their own words. Frequently, the feedback highlights positive as well as negative comments, both of which should go directly to staff for them to respond to.

FFT feedback is near real-time so healthcare providers and their staff can identify opportunities to make improvements to their services in a faster more responsive way.

Service providers can use their own follow up questions, which allows them to tailor them to specific local issues or service developments. The information gathered from FFT responses can be used to identify quick wins, areas for further investigation, common themes across the responses, or themes common to specific demographic groups that are specifically affected by an aspect of the service such as accessibility.

While providers are not required to share their FFT comments with NHS England, it may be possible for commissioners to put in place arrangements to see some or all of the responses in an anonymised format.

Through FFT we have seen that staff have been able to fix many of the issues highlighted by patients, and although they can be small things, they can have a big impact on patient experience. In addition, the positive comments can help to raise the morale of hard working staff.

Understanding FFT results

The responses to the FFT question are used to produce a score that can be aggregated to ward, site, specialty and trust level. However, on its own, the numerical data created by NHS FFT should not be used for direct comparison between different organisations.

This is because there is flexibility in the collection method, flexibility in the timing and it allows all patients to provide feedback rather than taking a structured sample approach to create statistically robust data. Therefore it is not possible to say with confidence that the results for one organisation are better than another.

The numerical FFT results are not without value however, and can be used in a variety of ways:

- ▶ Monitoring progress over time at different levels (eg ward, team, department) within an organisation
- ▶ Looking at the percentages of patients who say they would be “extremely unlikely” to recommend the service – fluctuations here can warrant further exploration
- ▶ Monitoring the numbers of responses – is an organisation hearing from appropriate volumes of patients? What is an appropriate volume of responses should be considered in the context of the care provided, and the regularity with which patients encounter the service.

Data are collected and submitted monthly and can be found here: <https://www.england.nhs.uk/fft/friends-and-family-test-data/>

Changes to the FFT

Changes to the FFT will take effect in April 2020. Keep up to date with plans online: www.england.nhs.uk/FFT/friends-and-family-test-development-project-2018-19.

What other sources of insight are there and how should commissioners use them?

Apart from the nationally collected survey results and FFT, which can be used to identify issues for further investigation, there are a range of resources, including:

- › Complaints
- › CQC inspection reports - <http://www.cqc.org.uk/content/inspection-reports>
- › Case studies

Insight might also be gained from a range of additional opportunities for patients to demonstrate their experiences of care. Commissioners are encouraged to look at available information relevant to an issue before commissioning new work.

Patient stories

Patient stories are an incredibly rich, powerful source of information. They bring to life issues that really matter to people, in their own words. They can be collected through a number of sources including letters, complaints, social media and websites like [CareOpinion](#), [PatientStories](#) and the [Life Story Network](#). They are a useful method of capturing evidence from a diverse range of people not always captured in surveys because of small numbers or because their opinion has not been sought, such as homeless people, refugees and asylum seekers. Patient stories are powerful for galvanising change at an individual and group level - inspiring empathy and action at all levels of an organisation.

Focus groups and in-depth interviews

Focus groups and in-depth interviews allow us to understand subjects in great detail and depth, allowing room for exploration of the issues. They can often be used to inform the development of questionnaires for subsequent surveys and/or exploring a topic more fully, in order to inform recommendations for policy.

Social media

Social media is a fast growing and important source of insight. There are some 500,000 comments about the NHS in England every week. These data sources can be harnessed to provide a deeper and richer understanding of people's concerns and interests relating to health services at both individual and collective levels. Using social media can also help to engage a wide range of people who are often already discussing the issues you are trying to address.

Observational work

Observational work is particularly useful when designing interventions which people might not want to talk about or where actual behaviour differs from reported research, as in this case study looking at how to reduce violence in A&E - <https://www.designcouncil.org.uk/sites/default/files/asset/document/ReducingViolenceAndAggressionInAandE.pdf>.

Insight from previous engagement activity

Engagement activity with citizens and communities provide rich sources of insight and feedback beyond the specific issue under consideration. They are, therefore, not only important tools for collective participation but also key sources of insight that can be used for wider purposes. For further information, please refer to our bite-size guides to participation - <https://www.england.nhs.uk/participation/resources/bitesizeparticipation/>.

Summary

There is a rich and varied amount of insight data, collected through national surveys, FFT, local surveys, patient engagement, consultations, and so on. No one source of insight can give you all the information to explain how people feel about a topic or get to the heart of a situation. Some tools are more effective at uncovering detail; others at giving a summative position; some will provoke an emotional response and some will point to the need for further investigation. The most effective use of these tools and the data they provide is when they are used in combination for discovery and action.

CONTACT US

This guide is part of a short series intended to help health-care providers and commissioners to make greater use of patient insight: <http://www.england.nhs.uk/ourwork/insight/insight-resources>

The work is overseen by the Insight & Feedback team for NHS England and NHS Improvement.

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This information can be made available in alternative formats, such as easy read or large print and may be available in alternative languages upon request. Please contact 0300 311 2233 or email england.contactus@nhs.net