

**Commissioning Brief
14/156 - New research on use and usefulness of patient experience data
Closing date: 11 Sep 2014 (two stage – outline to full)**

1. Remit of this call: main topic areas identified

Quality of care can be measured not just by the treatment received and changes in patient outcome, but also the way in which that care was delivered. To date, this has been assessed quite crudely by broad patient satisfaction surveys or global rating measures. These might cover whole hospitals or ask general questions which do not capture meaningful information about the care received. Elements of patient experience might range from process measures – time to wait for appointment or length of consultation – to more relational aspects of care. They might include satisfaction surveys (were you happy with the care you received?) and experience surveys (what happened to you during your stay?). All health and care organisations are now required to collect data on patient experience, in the form of national standards in the domain on patient experience in the NHS Outcomes Framework. This includes reporting of the NHS Friends and Family test, but organisations are also encouraged to supplement this mandatory information with other forms of information on the experience of care.

Although this country has led the way with a national patient survey programme in some form since 2001, this is a relatively new field of activity for research in this country. There is still uncertainty about how to collect the data in a timely way from different kinds of patients, present it in a meaningful way which stimulates action and how to align national requirements with local needs. There is debate about the best level in an organisation to share the data (ward, directorate, locality or community team) and how best to do this to improve performance, reflect on practice or identify system weaknesses. Evidence suggests that while many provider organisations are now capturing patient experience data of different kinds, less effort has been spent to date in using this information to improve the quality of services. Overall, there is little UK-based research on how best to make use of patient experience data or what organisations can do to ensure that patient feedback shapes services and care.

Four particular research gaps and service uncertainties have been identified around the use and usefulness of patient experience data.

- (1) What research is needed to make data more credible and useful?
- (2) What is the relative cost-effectiveness of different ways of using patient experience data to stimulate quality improvements?
- (3) What kind of organisational capacity is needed in different settings to interpret and act on patient experience data?
- (4) How should patient experience data be presented and combined with other information on quality, effectiveness and safety to produce reliable quality indicators?

There is overlap between the questions identified and it is likely that proposals will address more than one question described below.

(1) What research is needed to make data more credible and useful?

Although there is a reasonable evidence base on what matters to patients and key domains of patient experience, there are some important gaps in what data is collected. Data at a whole-organisation level is less helpful to drive change and a challenge is how to gather the data in a more efficient, timely manner to enable the collection of more granular data from larger samples so that data can be analysed at department or ward level. Research could also test when patient experience data collected from one clinical setting could be applied in another. Some work has been

undertaken on the reliability of information from social media and general ratings websites and more evaluation is needed of their value. Other kinds of content which could be tested further are probes to actively seek problems or examples of poor care from service users. It is also important that organisations understand how well they are caring for the most vulnerable patients, who may be excluded from many surveys to date. Methodological research is needed to test the validity and reliability of methods to collect patient experience data from those who are illiterate or cognitively impaired. Another important area of research is to investigate the use of family and carer ratings of care as well as or instead of experience data from service users.

(2) What is the relative cost-effectiveness of different ways of using patient experience data to stimulate quality improvements?

There are few high quality studies demonstrating the impact of using patient experience data to effect service change. Many existing studies are small-scale, without robust evaluation design. More studies are needed which measure the ways in which information drives change. Impact might be measured in different ways – from patient satisfaction rates (over time), patient ratings, clinical and organisational performance measures and other quality markers at different levels in the organisation. Process evaluation will be particularly important, including observational work to understand how organisations, teams and individuals interpret and act on findings. Completed research should help service leaders to identify the organisation and staff characteristics associated with effective use of patient experience data for different purposes and the mechanisms for achieving this. This might range from facilitated meetings at a ward or team level, to data benchmarking, to appointment of senior (board-level) patient experience champion. Studies could also look at the relative effectiveness and cost-effectiveness of different methods of data collection, given recent investment by many organisations in new mechanisms. This might for instance compare the impact of real-time text surveys, patient tracker devices and video kiosks with more traditional follow-up surveys after discharge and treatment in various forms (online, postal, telephone, face to face) in terms of potential to influence change. Methodological research is also needed to test the reliability and validity of using different forms of patient experience data as a measure of outcome to compare interventions or assess the impact of service changes over time.

(3) What kind of organisational capacity is needed to make sense of patient experience data

With the expansion of national surveys, some central guidance has been provided on issues such as sampling and reliability of data (www.nhssurveys.org). However, few organisations have sufficient analytical capacity to interpret complex data, especially in smaller primary care and social care organisations. Research is needed to understand the organisational capacity which is needed to make sense of data and draw reasonable conclusions from responses at a team or ward or practice level. This includes understanding of what level of patient data is sufficiently representative to initiate change or drive service improvement. Capacity is needed not just to understand quantitative data (such as when to adjust for bias) but also making sense of complex qualitative data, such as patient narratives or analysing results from a focus group. Some organisations have engaged patients and families in making sense of findings and this could be explored further.

(4) How should patient experience data be presented and combined with other information on quality, effectiveness and safety to produce reliable quality indicators?

Research is needed to identify the most effective way of presenting patient experience data so they are meaningful to staff. This includes content and format issues for different contexts, from ward or practice meeting to Board presentations. At present, patient experience data is not well aligned with other kinds of information captured at a hospital, practice or community or social care setting. Other data sources could be brought together when considering particular pathways or services. These include clinical effectiveness and outcomes data, including patient-reported outcomes (PROMS) data, patient safety data (from reported incidents to complaints) and other information on patient environment, cleanliness or care. Other kinds of routinely collected process information from audits and activity data can give valuable insights into patient experience, such as rates of cancelled operations, number of patient outliers, ward moves or incomplete patient information at time of consultation. An HS&DR study has already been commissioned around use of ward-based hospital dashboards to monitor safety and quality, but more work could be carried out on how best to use

patient or service user experience data in combination with other forms of intelligence to provide reliable quality indicators.

2. Purpose of call

The topic of use of patient experience data was highlighted as a top priority for the HS&DR programme in two consecutive years by clinicians, patients, service leaders and managers. This topic was further refined at discussion at a workshop in February 2014, where the focus was on making patient experience data usable and useful to the service.

3. Notes to Applicants

The NIHR Health Services and Delivery Research (HS&DR) programme aims to produce rigorous and relevant evidence on the quality, access and organisation of health services, including costs and outcomes in order to improve health and health services. It is focused on research to support decisions by frontline managers and clinical leaders on the appropriateness, quality and cost-effectiveness of care.

The NIHR HS&DR programme is funded by the NIHR, with contributions from NISCHR in Wales, the HSC R&D Division, Public Health Agency in Northern Ireland, and case by case contributions from the CSO in Scotland.

The programme operates two funding streams; researcher-led and commissioned. Researchers in England, Wales and Northern Ireland are eligible to apply for funding from either workstream under this programme. Researchers in Scotland may apply to the researcher-led workstream but are not eligible to respond to the commissioned workstream and should contact the CSO to discuss funding opportunities for healthcare delivery-type research

4. Application process and timetable

This call for proposals should be read alongside further supporting information and general guidance from the HS&DR programme on applications.

Should you have any questions or require any further clarification please refer to the NETSCC FAQs at [HS&DR programme - FAQs](#), if the answer to your question cannot be found please email your query to hsdrinfo@soton.ac.uk with the title for the call for proposals as the email header. Applicants should be aware that while every effort will be made to respond to enquiries in a timely fashion, **these should be received at least two weeks before the call closing date.**

The process of commissioning will be in **two stages** and applicants should submit **outline proposals** via the HS&DR website by **1pm on 11 September 2014**. All proposals will initially be checked for remit and competitiveness¹. No late proposals will be considered. No paper-based only submissions will be considered.

Applicants will be notified of the outcome of their outline application in Nov 2014.

Shortlisted applicants will be invited to submit a full proposal via the HS&DR website (a link will be sent to shortlisted applicants). Applicants will be notified of the outcome of their full proposal application in Apr 2015. Please note that these dates may be subject to change.

5. Transparency agenda

In line with the government's transparency agenda, any contract resulting from this tender may be published in its entirety to the general public. Further information on the transparency agenda is at: <http://transparency.number10.gov.uk/>
<http://www.contractsfinder.businesslink.gov.uk/>

¹ **'Non-Competitive'** means that a proposal is not of a *sufficiently high* standard to be taken forward for further assessment in comparison with other proposals received and funded by the HS&DR programme because it has little or no realistic prospect of funding. This may be because of scientific quality, cost, scale/duration, or the makeup of the project team