

Real-time Patient Feedback

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Citation for published version (Harvard):
Brown, H, Davidson, D & Ellins, J 2009, *Real-time Patient Feedback*. University of Birmingham, Health Services Management Centre. <<http://www.birmingham.ac.uk/Documents/college-social-sciences/social-policy/HSMC/publications/2011/real-time-patient-feedback.pdf>>

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**NHS West Midlands
Investing for Health
Real-time Patient Feedback Project**

Final Report

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Health Services Management Centre

January 2009

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Executive Summary

1 Introduction

- The West Midlands Strategic Health Authority has produced a Strategic Framework, *Investing for Health* which sets out a five-year action plan to improve health and health services and to meet the challenges facing the NHS in the West Midlands. The strategic plan sets out how services will be reshaped around the needs of the patient
- This report – commissioned from the Health Services Management Centre at the University of Birmingham - explores the methods used and issues involved in gathering, collating and analysing real time patient feedback and discusses best practice in terms of the methodologies and techniques used and how this feedback is acted upon by organisations across both NHS and non-NHS settings
- Real time patient feedback is concerned with the systematic obtaining, analysis, and reporting of feedback from patients following a recent experience of using health care services
- Real-time patient feedback provides organisations with an opportunity to increase their responsiveness to service users and the public at large in the design and delivery of health services by offering services that consumers actually want, in terms of quality and content.

2 Findings

2.1 Engaging people and soliciting feedback

- No one method of collecting feedback will reach every group within the community and no one method is suitable or preferred by everyone
- All the organisations contacted provided information that confirmed patient or service user and public feedback was important and valuable to them. This kind of feedback is also seen as highly valuable by other patients and service users
- A key component of patient enthusiasm for feedback is the power they are given to improve things for other patients
- Providing opportunities to give feedback is not an end in itself however. The exercise is only as good as the action that comes out of it.

2.2 Current practice in designing and undertaking survey feedback

- Often feedback survey design is determined by managers or researchers, rather than by patients
- Questions asked in surveys are often the wrong ones and do not collect the data required; this is often down to poor skills and knowledge in asking the right evaluation questions
- In order to maximise response rates, increase representation of the population as a whole and avoid sampling bias as far as possible, organisations will need to employ a range of methods to gather feedback. Organisations should also involve patients and the public in determining what is important to them and therefore what should be measured, bearing in mind that measuring satisfaction alone will not necessarily provide the sort of information an organisation can act upon to effect change
- The timing of data collection is a critical aspect to ensure organisations use feedback effectively. Data collected at different times will potentially provide different responses. When it comes to service and quality improvements, the 'fresher' the information, the more effective it can be. However when it comes to gathering feedback for long term strategic purposes, the timing of data collection is not necessarily as important as ensuring it is collected on an ongoing basis from a representative sample of the population and is used systematically and according to a clearly defined strategy
- Organisations are spending a considerable amount of time and resources on gathering data. While some organisations are using this information to good effect, this investment nevertheless risks generating a poor return if they do not approach this in a systematic way
- To both ensure effective use of feedback and action taken, organisations need to ensure that they develop a formal strategy and organisational processes for co-ordinating data collection, collation, analysis and dissemination
- Where responsibility lies for gathering feedback and analysis, reporting and taking action needs to be clear and understood by all within the organisation.

2.3 Issues to consider when using real time or near real time feedback

- The gathering of real-time feedback can bring clear advantages to an organisation. However it should be clear from the outset where real time fits into its overall strategy for gathering and using feedback
- Real time can increase the chances of feedback being put to effective use as staff recognise the ‘freshness’ of the information and perceive it as having greater validity. Staff particularly appreciate receiving feedback in the patient or user’s own words as this makes the comments more ‘real’ to them. The advantages and disadvantages of quantitative and qualitative feedback should also be considered. By effecting immediate changes, based on real-time data, it should also be possible for organisations to better understand what actions have had what specific effect
- Organisations will need to take into account the needs of all potential users when considering which technology it may wish to introduce
- All of the above should be considered carefully before organisations make an investment in real-time technology or services.

2.4 Products and suppliers

- There are a huge number of market research companies in the UK who provide a range of services including questionnaire and survey design and analysis, mystery shopper programmes and focus group facilitation
- There are a limited number that operate specifically in the healthcare market and only a handful that provide a total solution in terms of hardware, software and management reporting services
- The main suppliers in this regard are Dr Foster, The Picker Institute and Customer Research Technology (CRT)
- **Dr Foster’s** healthcare product, the Patient Experience Tracker (PET), consists of a hand-held device which provides its customers with a five question multiple-choice questionnaire. At present Dr Foster is currently working with 16 PCTs, 42 acute hospital trusts, 8 mental health trusts and one GP practice. Of those organisations that provided the name of its supplier, 10 use Dr Foster’s products
- **The Picker Institute’s** Frequent Feedback service also uses hand-held devices (PDAs) to administer its electronic surveys in conjunction with its technical partners - fr3dom. Of those organisations that provided the name of its supplier, three are using the Frequent Feedback service

- **CRT** provides a range of products, both hand-held, touch screen kiosks and online questionnaires to administer its 'Viewpoint' feedback system which was introduced to the healthcare market two years ago. CRT has also been the sole UK distributor of the American product Opinionmeter, though it is phasing this out now as it develops its own products. None of those organisations contacted, who named its supplier, used CRT, however information provided to HSMC lists 30 NHS clients, though these may not all be using the technology on an ongoing basis.

2.5 Current use of 'real time' methods and technologies

2.5.1 Face-to-face interviews/patient stories

- Face-to-face methods are likely to be the most inclusive, though will not generate the greatest number of responses in any given time period
- People like face-to-face methods for gathering feedback and they are effective for following up on any issues raised in order to understand why these are issues. However, these methods are time consuming, require an investment in training and can cost a considerable amount to administer when the 'researchers' require reimbursement or where front-line staff are taken away from their day-to-day activities in order to act as researchers
- Qualitative methods such as these can be an extremely rich source of data; however organisations need to take into account the moderating effect an interviewer's presence can have on responses.

2.5.2 Paper-based methods

- Paper-based methods are cheap, convenient and generally user-friendly, depending on a questionnaire's length and complexity
- It is possible to obtain large volumes of quantitative data though the use of paper-based methods for gaining qualitative data is limited
- Postal questionnaires result in poor and slow response rates, though these methods are favoured by certain groups of the population, such as older people and those of a lower educational standard
- Self-administered paper-based questionnaires can result in higher reporting of undesirable or socially unacceptable behaviour
- Comment or feedback cards can result in the reporting of mostly extreme responses.

2.5.3 Hand-held devices

- Sample size and the representativeness of that sample within inpatient settings must be properly monitored by organisations
- There is the potential for sampling bias to occur if staff screen out potential respondents for reasons other than capacity e.g. because an individual is likely to provide negative responses or because an individual may be considered a 'difficult' candidate for volunteers because of language barriers or disabilities
- The provision of alternative methods to collect feedback from those unable to take part in a ward-based survey is also recommended to ensure high response rates and meaningful results
- The routine collection of demographic data and monitoring of positive and negative responses should help to provide some reassurance against sample bias, whether the setting is an acute trust or PCT
- Organisations will need to spend a short time training staff or volunteers expected to administer surveys, using hand-held devices. Where volunteers are used, this will require some co-ordination in terms of recruitment, training and scheduling
- Where possible, surveys should be self-administered, with patients and service users given privacy to complete, in order to ensure anonymity
- Organisations will probably wish to use different questions in different settings and for different purposes. A contract with a supplier which gives maximum flexibility to vary questions, as required, will probably be important for most organisations
- As with any questionnaire, a pilot phase to test out the questions used and to address any operational issues arising from the use of hand-held devices is critical.

2.5.4 Kiosks

- Kiosks provide an alternative means to complete a survey anonymously and are generally sited in areas of high footfall, where a static solution is appropriate. Organisations must work to ensure that the kiosk is visible, well-maintained and its purpose explained
- Sample representativeness is a serious drawback as people self-select themselves to participate. Though they are generally considered user-friendly, certain groups, such as the less technically literate, are less likely to use a kiosk, especially where there is no ready assistance available.
- Time pressures may prevent people from using kiosks to complete surveys

- The extremes of opinion are often provided by these methods
- Kiosks can be vulnerable to misuse.

2.5.5 Bedside terminals

- This method may overcome some of the problems of sampling associated with hand-held devices handed out to people
- Incentives could be provided such as free credit on the terminals, in order to increase response rates. As the cost of using these units is often significant, this could be a very welcome incentive to patients.

2.5.6 Telephone interviewing

- A distinction should be drawn between telephone interviewing whereby respondents are determined randomly and the call is opportunistic and telephone interviews which are either pre-arranged with the respondent or where the respondent is expecting a follow-up call at some point after an episode of care
- Response rates are likely to be higher with the latter than the former, though for the latter to be effective, organisations must collect contact telephone numbers for patients and service users as a matter of routine
- Where people are contacted opportunistically, telephone interviewing may be viewed as intrusive. However this can be a convenient method for people where an interview is pre-arranged
- Computer Assisted Telephone Interviewing (CATI) can reduce data entries as responses are keyed directly into a computer. Results can be analysed quickly and continuously. CATI is also a cost effective method
- Telephone questionnaires with CATI are usually shorter, would allow for less detailed responses and may not give people enough time to provide well considered answers
- These issues can be redressed where an interviewer is used, though this is a more costly option. The presence of an interviewer however may produce 'moderating results' in people's responses
- The lack of universal coverage for telephone ownership means that the use of telephone interviewing would result in the under-representation of certain groups of the population i.e. younger households and the socio-economically disadvantaged. Therefore telephone interviewing whether computer assisted or not, is best used where precision of results is not required. (Breen, Donnelly, Chalmers 1992)

2.5.7 Online questionnaires, computerised and web based systems

- The provision of personal information and feedback via the internet will not generate high responses where trust and understanding of technology is low
- Self-administered computerised questionnaires result in better responses to sensitive questions as they avoid the moderating effects of an interviewer's presence
- Computerised questionnaires allow for more detailed answers to questions, complex routing and the use of graphics and other visual aids. Respondents choose when it is convenient for them to respond and will usually have more time to deliberate and reflect. However, respondent fatigue is more evident in online surveys
- It is possible to gather a lot of data in a short space of time with online questionnaires but a minimum time period should still be given for respondents to submit completed questionnaires
- Internet coverage is not universal resulting in concerns over representative samples
- The use of websites to provide feedback is quick, easy and convenient, though this method may be more appropriate for certain types of feedback such as general comments and opinions rather than concerns or specific issues
- Online communities are useful for generating large volumes of qualitative data from people, on a specific topic or theme. They are quick and convenient and their use can increase response rates. This method is also useful for gathering ongoing feedback over longer periods of time
- These communities require a significant amount of management and maintenance however. Recruiting the right members will be an important issue for organisations to address. Samples cannot be representative as internet coverage is not universal.

3 Good practice in using the data

There are two factors that are critical to the effective use of patient feedback. First, data should be gathered using *robust methods*, from a cross-section of different groups, in ways that are acceptable to patients and are appropriate to their particular circumstances. Second, those *data should be fed back to staff and used by them* to improve the patient experience.

3.1 Robust approaches for designing and using survey feedback

- The evidence from the literature and this study suggest that together, the following key points constitute a robust approach to designing and using survey feedback methods including real time methods.

3.1.1 Clarity of purpose and timing

- An organisation should ask itself what it is trying to achieve by using real-time feedback and whether it can provide the right sort of evaluation. While real-time feedback is useful as part of a range of tools and techniques to gather feedback, it is unlikely to be a cure all
- The timing of data collection is a critical aspect to ensure organisations use feedback effectively. For service and quality improvements, the ‘fresher’ the information, the more effective it can be. For long term strategic purposes, the timing of data collection is not necessarily as important as ensuring it is collected on an ongoing basis from a representative sample of the population and is used systematically and according to a clearly defined strategy.

3.1.2 Use of ‘real time’ methods

- The gathering of real-time feedback can bring clear advantages to an organisation however it should be clear from the outset where real time fits into its overall strategy for gathering and using feedback
- Organisations will need to take into account the needs of all potential users when considering which technology it may wish to introduce
- While patient feedback from surveys and technology identifies broad areas or issues where improvement is needed (the what), rarely does it pinpoint specific problems or provide answers as to how these might be resolved (the why or how). Often further information needs to be gathered to find out the cause of the problem and this may require additional resources, time and commitment. In these cases, qualitative approaches have clear benefits in finding out answers to ‘why’ questions; the use of patient stories or volunteer interviewers can be effective.

3.1.3 Survey design

- Often feedback survey design is determined by managers or researchers, rather than by patients. Organisations should involve patients and the public in determining what is important to them and therefore what should be measured, bearing in mind that measuring satisfaction alone will not necessarily provide the sort of information an organisation can act upon to effect change

- In order to maximise response rates, increase representation of the population as a whole and avoid sampling bias as far as possible, organisations will need to employ a range of methods to gather feedback.

3.1.4 Engagement

- Given the relationship between feedback methods and the engagement of people, providing a range of methods and opportunities to solicit feedback is recognised as an important element for an engagement or communications strategy by organisations; it is universally acknowledged that no one method will reach every section within the community and no one method is suitable or preferred by everyone
- There is considerable evidence that response rates vary among different groups and certain groups are significantly under-represented such as BME communities and people with disabilities
- A key component of patient enthusiasm for feedback is the power they are given to improve things for other patients.

3.1.5 Technical expertise

- Questions asked in surveys are often the wrong ones and do not collect the data required; this is often down to poor skills and knowledge in asking the right evaluation questions. Clarity over what is being measured or evaluated will determine whether the right questions are being asked. For this to be effective, skill and expertise is required to formulate the right questions, analyse data and to turn feedback into actionable information.
- Questions should be worked up from patient needs into key priorities and these used to determine the questions and measurements required.

3.1.6 Organisation and administration

- Organisations are spending a considerable amount of time and resources on gathering data. While some organisations are using this information to good effect, this investment nevertheless risks generating a poor return, if they do not approach this in a systematic way
- To both ensure effective use of feedback and action taken, organisations need to ensure that they develop a formal strategy and organisational processes for co-ordinating data collection, collation, analysis and dissemination. For services that are provided across organisational boundaries, this should include engaging with Local Authorities to develop a joint approach for both providers and commissioners
- Where responsibility lies for gathering feedback and analysis, reporting and taking action needs to be clear and understood by all within the organisation.

3.1.7 Feedback loops

- A feedback loop to staff, patients and service users is a critical element of the process. Without this, organisations risk losing public trust and ongoing engagement as results will not be implemented
- Staff particularly appreciate receiving feedback in the patient or users own words as this makes the comments more ‘real’ to them. By effecting immediate changes, based on real-time data, it should also be possible for organisations to better understand what actions have had what specific effect
- Feedback is more effective when the findings are disseminated in tandem with educational programmes or quality improvement guidance
- However, we know that using robust methods alone is still insufficient for effective use of feedback. Organisational action needs to be taken.

4 Implementation

Implementation of real-time patient feedback requires a strategic and systematic approach if it is to be useful and successful. There are a series of steps that when taken together, can provide the basis for a strategic approach to implementing survey feedback. These include:

4.1 Developing a person-centred approach

- Experienced based design (Bate and Roberts, 2007) is one of the more radical and innovative approaches currently being developed in healthcare
- This approach is about being mindful of experience and the need to build that mindfulness into service delivery. It draws on the design sciences and the design professions, such as architecture, computer, product and graphic design for its ideas
- Within a design framework, the focus for change shifts from change to improvement and from process to outcomes, ultimately to lead to a better experience for service users/patients
- The key challenge to staff taking a person-centred approach would be to help users/patients involved “to design and develop a process that will lead to services being better in the user’s terms “(Bate and Roberts, 2007:46).

4.2 Creating a structured process for quality improvement

- Evidence from the organisational change literature (Cummings and Worley, 2001) suggests that the first and most important task in implementing change is to establish an infrastructure for the change process. Without an infrastructure, a project is unlikely to succeed or develop with any coherence. This is also articulated in the healthcare literature for survey feedback
- Given the multiple factors found to be important to quality and safety improvement, Øvretviet (2005) suggests building a ‘system’ of leadership improvement which:
 - Consists of all the formal and informal leaders, teams and groups which support improvement as part of their everyday work;
 - Identifies and stimulates a variety of champions to collectively agree priorities and methods for improvement, and ensures this is led by those champions in a consistent way and in a common direction;
 - Values and harnesses the energy of ‘ordinary’ leaders¹; and
 - Institutionalises improvement and reduces dependence on senior managerial leaders, who are often transitory.
- The most common finding associated with successful or failed improvement concerned the ‘engagement’ of senior clinicians, in particular doctors

4.3 Adopting organisational development principles

- The organisational development literature (Cummings and Worley, 2001; Block, 2000; Neumann, 2007) suggests a number of factors which are essential when creating an infrastructure for change
- Neumann (2007) offers some organisational development and change *design rules*, which are useful to consider when thinking about the process of change.

4.4 Feedback to, and involvement of, staff

- Providing the results of surveys and feedback to staff, and providing staff with the opportunities to use this information, is as critical as providing it to patients and members of the public

¹ People who have been employed some time and “have detailed knowledge of how work is organised – who does what and how – and know who to contact to get things done and who are known widely in the organisation....These people can also block or slow down change, but if inspired and allowed to contribute have a significant role to play (Øvretviet, 2005: 422-3).

- For change to occur two crucial things had to happen:
 - Survey information had to be reported to service managers/supervisors; and
 - The results needed to be discussed and service improvements planned together with the staff that provide the service.
- Intensive group discussions for utilising the results of surveys can be an effective tool for introducing positive change in a business organisation, and is more effective than traditional training courses.

4.5 Working with human responses to change

- People's responses to change are varied, and are neither simple nor predictable
- Hoyle (2004: 87) states that as people engage with change they will be "taking risks, generating uncertainty and facing the possibility of failure which can evoke anxiety in themselves and others around them."
- The literature on change suggests that if the *people* issues are not identified and worked with effectively, then a number of problems will arise
- The research on managing change, is that ignoring, denying or avoiding addressing people's responses to change will negatively impact on the change effort, because the feelings and attitudes of staff are not worked through
- Whatever approaches are taken, knowing what people are feeling and thinking will help those leading change to shape the change process, and legitimise people's responses to change.

5 Implications for commissioning and strategic policy implementation

- Real-time patient feedback is a source of data and activity that has the potential for driving a commissioning agenda. For the NHS West Midlands and PCTs, the key question is how do they want real-time patient feedback to be used to drive commissioning decisions locally?
- Given the paucity of research in relation to use of real-time patient feedback for commissioning, we cannot provide evidence or conclusions about what works. We can however discuss the implications for

commissioning and indicate some of the thinking and ideas currently being worked on in the healthcare field.

5.1 Accountability

- Organisations need to hold themselves to account for acting on the feedback that they gather. The Board, as the accountable body within a Trust or PCT, should be the accountable body for acting on feedback, with the Chief Executive and Medical Director being ultimately responsible for implementation.
- Just as organisations monitor and report their use of finances, so they should monitor and report on engagement and involvement with, and feedback from, service users and patients. This might include the Board:
 - Assuring itself that the organisation is properly equipped for PPI
 - Requiring, reviewing and responding to reports from teams/wards/services about how they are responding to feedback from their users
 - Showing leadership by example e.g. demonstrating to the rest of the organisation how it takes feedback into account in its decisions.

5.2 Implications for SHAs

5.2.1 Providing frameworks for action

- Responses to HSMC's questionnaire argued strongly against an imposed set of outputs. Given their strategic role, at the very least SHAs should establish a process for whole health economies and set out a broad framework, based on outcomes that can then be worked with at a local level through commissioning.

5.2.2 Benchmarking and comparison at whole health economy levels

- It might be useful for SHAs to establish priority areas across a whole health economy, and gather feedback as part of a rolling programme in every Provider Trust; this data would be collated in order to benchmark and compare service outcomes
- The benefit of this approach would be to raise standards across a whole region. However, as shown in this report, there is a danger in relying on data that is collected in one time period, as it might distort the true picture of experience across a more extended period of time.

5.2.3 Investment for capacity and capability

- Each organisation surveyed has its own approach to resourcing the gathering of feedback and translating this into action. Responsibility and

accountability for this sits within different departments and there is no standard model for how this is managed and resourced

- What is clear however is that every PCT stated that increased investment for capacity and capability to collect, collate and analyse data and follow up in implementation was required. This is a function that SHAs can potentially undertake across whole health economies.

5.2.4 Metrics for assessing user experience

- If the gulf between what we can buy as customers and what we get as public service users is to be bridged, SHAs must take a strategic role in ensuring that metrics for user experience that match needs within local health economies are actively used in commissioning discussions. Links with the Quality Observatories and CQUIN are essential.
- The literature clearly provides some guidance for this, for example Hughes, (2004), Perri 6 (2003) and Klein and Millar (1995) discuss consumer choice goals, which might contribute to metrics for commissioning, against which evidence is assessed
- However, Bate's and Robert's (2007) plea needs to be heeded; that what ever indicators are developed, the design and process will lead to services being better in the user's terms.

5.3 Implications for Commissioning

5.3.1 Real time or right time

- For long-term strategic purposes, the timing of data collection is not necessarily as important as ensuring data is collected on an ongoing basis from a representative sample of the population and that this is used systematically and according to a clearly defined strategy, which includes benchmarking
- However, there needs to be a trade off between these more robust and standardised processes for data collection and analysis, and processes that enable commissioners to respond quickly to local population needs, individual organisational priorities and user experience, which demonstrates that it is making a difference in the short term.

5.3.2 Managing public expectations

- Our study found that there was some concern about managing public expectations.
- A culture change in the way in which services view and work with service users e.g. experienced based design (Bate and Roberts, 2007) might mean there will never be a situation where matters cannot be changed or are not

up for discussion. Instead, there needs to be a process of *robust dialogue*, which works with the realities and lived experiences of service users, staff and government targets.

5.3.3 Prioritisation and decision-making

- Decisions are often made, and methods determined, by staff rather than by patients or the public
- Evidence suggests that the public doesn't always have the same priorities and values as commissioners when it comes to making decisions on the funding of services
- The results from asking the public about priorities and allocation of resources, particularly in relation to public health type services, may therefore pose a dilemma for commissioners
- Despite this dilemma, commissioners should involve patients and the public in determining what is important to them, including priorities based on their experience of using services
- Commissioners need to be alert to also seeking the views of people who often don't access services such as those from black and minority ethnic communities, people with disabilities, elderly people and young people.

5.3.4 Bringing patient experience into contracting discussions

- Patient experience and outcomes – whether gathered in real time or otherwise – is fundamental if both providers and commissioners are to “construct a shared... and deep sense of purpose...” (Bate and Roberts, 2007:63)
- Contracting meetings with providers, until recently, have typically involved setting a base line for expected levels of activity (using historical data) at the beginning of a financial year and comparing activity in year against expectations. The focus of the discussions traditionally has been on activity levels and finance
- More recently, quality of care has started to enter these discussions, with the development of quality indicators and an expectation that providers will compile a portfolio of evidence. The case study of Bradford and Airedale (see section 5.2.4 of main report) is a good example.

5.3.5 Using real-time feedback to drive commissioning decisions

- There are currently a range of uses of real-time patient feedback to support strategic service planning and decision making, procurement and contract monitoring

- In some cases PCTs are using feedback to inform commissioning decisions, for example to increase GP opening hours, increase community mental health workers and to launch an Expert Patient Programme in Urdu
- One of the key issues that emerged was the need to work with commissioners to understand how information can be used to trigger decision making as part of the commissioning cycle
- The E-cycle seems a useful tool for also considering the place of real-time feedback. The E-cycle could be promoted to provide a measure of consistency of approach across organisations.

5.3.6 Accounting for quality

- There are a number of different activities currently being considered/planned that relate to accounting for quality
- Consultation by the Health and Social Care Information Centre is underway on possible metrics; with local trusts and PCTs deciding which metrics they want to use
- CQUIN (Commissioning for Quality and Innovation) - this is envisaged as a "pay for performance" scheme by which PCTs hold back a percentage (envisaged as 2%) of the contract sum from providers. This is released when the Trust delivers a number of pre-agreed quality improvements – anticipated as delivery of a specific level of performance against various metrics. While this level seems low, Monitor² suggests 5% is sufficient to bankrupt an institution so 2% could provide sufficient leverage and incentive
- Quality Observatories (like public health observatories) - teams of staff to collect, analyze and share data on the quality metrics agreed locally
- Quality Accounts - rather like annual accounts, these are formal publications by providers which show their performance against the locally agreed metrics plus the data used to register with the Care Quality Commission
- It is likely that the DH will want both CQUIN and Quality Accounts to use metrics where the data is derived from near real-time patient feedback. With CQUIN the Trust will receive money for delivering a specific level of performance. Quality Accounts will enable Trusts to show the scale of improvement.

² Regulatory body for NHS Foundation Trust

5.3.7 Competencies, skills and behaviours

- Of the 11 competencies identified by the DH in *World Class Commissioning: Competencies* (2007), six have obvious relevance to real-time patient feedback
- However, we suggest that there are five further competencies that would enhance commissioners knowledge and skills:
 - Think whole systems
 - Be person centred
 - Design for human experience
 - Ask the right questions
 - Embed equality into everyday practice.

5.4 Two questions and one caution

5.4.1 What will trigger action and change?

- There are two important questions that remain to be answered:
 - Are organisations willing to take the risk and be prepared to innovate in the absence of robust research evidence about whether real time patient feedback makes a difference; and
 - What would be/is a significant enough response rate, for an organisation to act and invest in making changes - if one person makes a comment, if 10 people make the same comment, if 50 make the same comment?
- With large-scale patient surveys, it was always expected that a large number of patients reporting problems would be sufficient to trigger action, with systems such as *Problem Scores*³ developed by the Picker Institute helping to systematically analyse and prioritise. However, this never really happened, and one reason why is that organisations often argued that the data was out of date
- This, in part, is where the drive for real-time feedback has come from. But the sample sizes for real-time feedback are likely to be much smaller, so will it be magnitude of problems (rather than sheer numbers) that count now or something else?

5.4.2 Human services require human relationships

- The development of new technology is providing innovative and enabling ways in which the human services can be more person-centred, responsive and improve the quality of care
- However, there is a danger that technological solutions will become a proxy for human contact. Highest on the list of complaints from patients

³ The higher the score, the more important it is to address the issue

about their care is how they are treated by people, with lack of respect and dignity cited as key issues. Embedded in a lack of respect or dignity is the lack of relatedness

- Real-time patient feedback through technological solutions has limitations, not least because it can only gather responses to 'what' questions. The 'why' and 'how' questions require face-to-face methods to drill down and understand the experience of the person
- Technology has an important part to play, but its introduction needs to be thought through carefully, to ensure that those providing direct care for patients don't just regard themselves as transactional suppliers.

6 References

Bate, P. and Robert, G. (2007) Toward a More User-Centric OD, in *The Journal of Applied Behavioural Science*, Vol 43, No. 1 March 2007 pp 41-66

Block, P. (2000) *Flawless Consulting*, San Francisco: Jossey-Bass

Cummings, T.G. and Worley, C.G. (2001) *Organisational development and change* 7th edition, Cincinnati, South-Western College Publishing

DH (2007) *World Class Commissioning – Competencies*. London: DH

Hoyle, L. (2004) From sycophant to saboteur: responses to organisational change, in Huffington, C. Armstrong, D. Halton, W. Hoyle, L. and Pooley, J. (2004) *Working Below the Surface: The Emotional Life of Contemporary Organizations*, Tavistock Clinic Series, London: Karnac pp 87-106

Hughes, M. (2004) (ed) *Enabling Choice: A Report to the Local Government Association*, University of Birmingham, School of Public Policy

Klein, R. E. and Millar, J. (1995), 'Do-it-yourself social policy: searching for a new paradigm?', *Social Policy and Administration*, 29(4): 303–16.

Neumann, J. E. (2007). *Applying Design Rules for Whole Systems Intervention*, University of Birmingham's MSc in Leading Public Service Change and Organisational Development

Øvretveit, J. (2005) Leading Improvement, in the *Journal of Health Organization and Management* Vol 19, No. 6, pp413-430

6, P. (2003) 'Giving Consumers of British Public Services More Choice: What can be learned from Recent History?' *Journal of Social Policy*, 32: 239-270

1 Introduction

The West Midlands Strategic Health Authority has produced a Strategic Framework, *Investing for Health* which sets out a five-year action plan to improve health and health services and to meet the challenges facing the NHS in the West Midlands. The strategic plan sets out how services will be reshaped around the needs of the patient. This framework has identified a number of projects targeted on areas where the SHA considers progress must be made to support the aspirations set out within *Investing for Health*.

One of these projects – Real-Time Patient Feedback – is concerned with the systematic obtaining, analysis, and reporting of feedback from patients following a recent experience of using health care services and the use of this information to drive service improvements and ensure commissioning decisions are being made with reference to credible, relevant and up-to-date information.

Real-time patient feedback provides organisations with an opportunity to increase their responsiveness to service users and the public at large in the design and delivery of health services by offering services that consumers actually want, in terms of quality and content.

This report – commissioned from the Health Services Management Centre at the University of Birmingham - explores the methods used and issues involved in gathering, collating and analysing real time patient feedback and discusses best practice in terms of the methodologies and techniques used and how this feedback is acted upon by organisations across both NHS and non-NHS settings. Best practice case studies incorporate national and international examples.

2 Context

2.1 The citizen as consumer⁴

Samli (2001) asserts that at the beginning of the 21st Century we are in the midst of a shift in power from producers to consumers, where *choice* has become a route to *responsiveness* in the design and delivery of public services.

“...if the public can exercise choice, then a service is more likely to be responsive to their needs and wishes.” (Hughes, 2004: 1)

Hughes suggests that the exercise of choice is not on a single dimension. Key to the dimensions they identify is “*How is the service provided? Does it empower*

⁴ Critical social policy commentators have suggested that the wish to introduce market forces has converged with long standing concerns and critiques about inadequate services. This links both to peoples’ dissatisfaction with welfare provision, and as a product of the 1990s “new consensus on the importance of the individual consumer-citizen...” (Spandler, 2004:190).

and respect the individual service user? Does the service setting appear to be clean, well-organised, friendly and trustworthy?”(Hughes, 2004:5).

Klein and Millar (1995) define the goals of consumer choice as:

- *Outcomes* (choice itself has positive benefits for consumers)
- *Acceptability* (it may be politically important for government to be seen to offer consumers choice)
- *Satisfaction* (consumer satisfaction is raised by consumers having choices, typically about *content* and *level* but also of *provider*)
- *User convenience* (in practice services will be organised around this recognition)

Perri 6 identifies several important goals concerned with promoting characteristics of service supply-side systems. One of the key service-level goals is that of *responsiveness* (6, 2003). He suggests that, in part, this is about “promoting competition or at least contestability, as a discipline upon providers to offer service content that consumers actually want, in respect both of quality of current service models and innovation in content” (*ibid*:244).

The notion of the citizen-consumer has been central to evolving government policies and public service design for the last 20 years, and is central to the current government’s vision for world class public services (*Excellence and Fairness*, 2008):

“The yardstick for success should not only be whether services have improved on last year’s results but also whether they are among the best in the world. It should also not be simply how public services compare against each other, but how they compare against the best provision available to those who can afford it in the very best private sector organisations, or against the most trusted third sector providers. The aspiration should be for genuinely world class public services that contribute towards a fairer and more prosperous society while delivering value for money to the taxpayer.” (*Excellence and Fairness*, 2008:10)

In this context, effective commissioning is a corner stone of the Department of Health’s (DH) agenda for improving the quality of care provided to people and extracting best value from public resources. Over the last year, the phrase *world class commissioning* has taken root signalling increased ambitions for commissioning to meet healthcare challenges. (*World Class Commissioning: Vision*, 2007).

2.2 Healthcare policy

2.2.1 World class commissioning

The DH vision for world class commissioning is that it will deliver better outcomes and better value; that people will have more choice and control over the services they use and that investment decisions are made in an informed and considered way, ensuring the delivery of improvements.

While priorities may be developed locally, there is clear guidance as to the knowledge, skills, behaviours and characteristics effective commissioners will be expected to develop. These include: effective engagement with public and patients - actively seeking the views of service users and carers to inform commissioning decisions and the management of knowledge and assessment of needs; and collecting high-quality and timely information from sources including patients and the public.

...This new relationship with the public is long term, inclusive and enduring... Decisions are made with a strong mandate from the local population... (World Class Commissioning: Vision, 2007).

2.2.2 Darzi next stage review

The *High Quality Care for all* report (DH 2008a) states that patients will be able to increase their influence over NHS resources and that payments to hospitals will be dependent not just on activity volumes but quality of care too. A range of measures covering safety, clinical outcomes, patient experience and patients' views on the success of their treatment will be used to measure quality of care. Provider organisations will therefore need to be mindful as to how patient experience is sought, measured and reported in order to convince commissioners what they should be paid for the relevant proportion of the quality of care component.

A guidance document entitled *Real Involvement* (DH 2008b), published this October and requiring PCTs to engage better with patients and the public in developing plans for local health services, also follows on from Darzi's recommendations that changes to services should be transparent, locally-led and for the benefit of patients. This strengthened 'Duty to Involve' guidance takes effect from November '08 and is expected to be included within the NHS Constitution.

This will undoubtedly build on the principles for effective patient and public involvement previously developed by The NHS Centre for Involvement and it may be helpful to provide a brief summary of those here, as follows: organisations must be clear about the purpose for involvement and ensure there are adequate resources available to undertake it – this will include equipping staff with the necessary skills to undertake involvement and to act upon the results; organisations should focus on involvement as a means of improvement and must demonstrate change as a result of involvement; a systematic approach, linking corporate decision-making to the community's opinions and views, with top-level commitment and leadership is therefore critical to effective involvement.

Organisations must be clear about the objectives of involvement and be honest about what can and can't change as a result. Opportunities for people to be involved must be promoted and a variety of methods are offered so that preferences for the way in which people wish to be involved can be accommodated. A concerted effort should be made to include people whose

voices are seldom heard and support should be available to ensure all patients and the public can be involved in whichever way they wish. An important aspect of this support will be to share information and knowledge to ensure people understand the issues and can make a worthwhile contribution.

Organisations should advise people that their views will feed into the decision making processes and finally organisations must provide feedback to people about what has been learned from the process of involvement and what actions will be taken as a result. Closing the loop by feeding back what changes have happened as a result of information being received will be important in building local trust and legitimacy.

Following on from these policy documents, issued as a result of the Next Stage Review, Alan Johnson, Secretary of State for Health, announced on 24th September 2008 that over the next 12 months every hospital trust will be expected to collect *immediate feedback* on hospital care in order to know within two weeks of treatment how patients felt about their care.

2.2.3 Quality standards

At present, patient experience is taken into account within the Fourth Domain of Standards for Better Health (2004) – the performance framework for the NHS. The Fourth Domain - Patient Focus – includes Developmental Standard D8 which states ‘Health care organisations continuously improve the patient experience, based on the feedback of patients, carers and relatives.’

While the Fourth Domain is more applicable to providers of services, the Fifth Domain – Accessible and Responsive Care is most applicable for commissioners. Within this Domain, Core Standard C17 states: ‘The views of patients, their carers, and others are sought and taken into account in designing, planning, delivering and improving health care services’ while Developmental Standard D11 states: ‘Health care organisations plan and deliver health care which reflects the views and health needs of the population serviced ...’

The Healthcare Commission is due to be formally replaced by the Care Quality Commission from April '09. The new system (out for consultation in Dec 2008) of ‘periodic reviews’ for providers will assess against core standards, national priorities, financial management and on the use of the Mental Health Act and Mental Capacity Act. Assessments will make sure people have meaningful information about services to help them make choices and exercise greater control over their care and also assess the safety and quality of services. It is not known whether this new process will continue in the same format as the existing one. Chief Executive of the new Commission, Cynthia Bower, has stated that existing information and risk-based inspection will continue, to minimise the administrative burden on organisations (CQC 2008).

In a recent article published by the HSJ, the outgoing Chair of the Healthcare Commission, Sir Ian Kennedy, provided his own thoughts on how the process could be improved - by measuring things that are important to patients and their carers. He suggests that standards should focus on three things: safety and quality; clinical outcomes and patient experience and that these should be measured not by the existence of processes but by outcomes.

Sir Ian advocates the supplementation of the annual health check with ‘real-time surveillance’, so organisations can spot potential issues before they become problems and to enable ‘the regulator to provide everyone with an up-to-date picture of performance.’

The Department is currently running an online consultation with staff on the usefulness of a list of 400 metrics, already used, to help determine a ‘new generation’ of quality indicators at national, regional and local level. Strategic Health Authorities are expected to report back from their regions by the end of January. (Measuring for Quality Improvement: the approach 2008c)

2.3 Local government policy

The NHS is not alone in grappling with the issue of how to obtain ‘customer’ or ‘citizen’ feedback in a timely, systematic way and how to use this information to manage performance, improve services and develop strategic planning. Local Government is working through similar issues and there are very obvious advantages to the two work streams making the appropriate connections.

2.3.1 Outcomes, targets and standards

A joint document from the Office of the Deputy Prime Minister (ODPM) and the Treasury, ‘*Securing better outcomes: developing a new performance framework*’ published in 2005 sets out an assessment framework for Local Authorities based on fewer national targets and increased local accountability. To achieve this and demonstrate service quality, local authorities need to gather good customer intelligence and be responsive.

The Cabinet Office has developed a national Customer Service Excellence standard for public services. The tool is designed to enable organisations to drive customer-focused change and emphasises the development of customer insight by understanding the user’s experience of services and measuring customer satisfaction.

According to the document *Customer Service Excellence: The Government Standard (2008)*, and its first criterion Customer Insight, a critical part of the approach for organisations is ‘Effectively identifying your customers, consulting them in a meaningful way and efficiently measuring the outcomes of your service It is not just about being able to collect information. It is about having the ability to

use that information, and developing a culture within your organisation that values this kind of understanding and constantly looks to improve.’

The standard goes on to list 11 elements of the Customer Insight criterion such as making consultation of customers integral to service improvement and advising customers of results and actions taken and using ‘reliable and accurate methods to measure customer satisfaction on a regular basis.’

2.3.2 Initiatives within the West Midlands

The Local Government Association is funding a number of initiatives in the West Midlands. A pilot is underway to introduce mystery shopping within a PCT and corresponding council, to explore the principle of using service user information across organisational boundaries in order to map customer journeys. Another county council has plans to develop a cohort of Community Researchers to engage more effectively with *Seldom Heard Communities*⁵.

The West Midlands Regional Improvement and Efficiency Partnership (RIEP) – an agency set up to support local government by sharing best practice – has recently surveyed local authorities in the region on their use of different sources of intelligence to inform the Improvement and Efficiency West Midlands (IEWM) project, ‘*Preparing for Insight and CAA: a Customer Focused Approach to Performance Management*’. The project involves Birmingham, Herefordshire, Sandwell, Stoke-on-Trent, Stratford, Walsall, Warwick and Worcester Councils. Emerging findings from the IEWM project suggest that while considerable amounts of ‘customer’ information is gathered by local authorities, it is not co-ordinated effectively and full advantage isn’t being taken of the potential for information sharing between departments and organisations. This is generally the experience of other councils elsewhere, though Barnet Council is exploring the potential of web-based technology to share information between departments and other agencies. (See Section 4.5.9)

In addition, the Programme Board for the Department of Communities and Local Government (previously the Office of the Deputy Prime Minister) has commissioned a short-life project to ascertain public sector, national and international best practice in *providing* timely information to citizens. The project will consider what sorts of real-time information people want and need from councils. Leeds Metropolitan Policy Research Institute is due to publish its findings in January ’09.

⁵ The term ‘seldom heard’ is relatively new and has replaced ‘hard-to-reach’ as the preferred terminology for excluded groups of people or those who have traditionally experienced difficulties with access to services such as the homeless, people with addiction problems, people from black and ethnic minority (BME) communities and those with learning or physical disabilities

3 Research methodology

Researchers acknowledge that there is no single strategy which will ensure every piece of relevant literature is accessed on a given subject. (Greenhalgh and Peacock 2005, cited by Aveyard 2007) Given the limitations of using computerised searching tools, researchers generally employ a search strategy which involves a variety of means to obtain relevant material.

For this project, HSMC undertook an initial data gathering exercise via the world-wide web in order to glean an overview of the extent to which real-time feedback data gathering was taking place within a range of organisations, the types of methodologies used to do so, the suppliers of these methods and their customer base. Useful literature was identified which led to other examples being discovered - a number of articles were obtained from the International Journal of Market Research using this method.

The type of approach used in this case is known as 'snowball sampling' (Greenhalgh and Peacock 2005, cited by Aveyard 2007), where the evolving search strategy is responsive to the literature obtained.

This approach resulted in the identification of organisations using real-time technologies, both NHS and non-NHS, representatives of a number of which were subsequently interviewed. In addition HSMC spoke to individuals from organisations such as the Health Care Commission, Patient Information Forum and Department of Health in order to gain additional information. In total HSMC contacted well over 100 organisations during the course of its research (this includes organisations that were involved in seeking customer views in general as opposed to real-time only). Documents were also obtained from the Department of Health and organisations such as Dr Foster, RSe Consulting, IDeA, LGA, and the National Social Marketing Centre.

3.1 Literature search

Two literature searches were undertaken. First a search was undertaken using the Health Management Information Consortium Database (HMIC). HMIC combines the databases of the King's Fund Library and the Department of Health Library. It is updated bi-monthly and is considered to be a key resource for references relating to health management.

An initial search using the key words, 'real time patient feedback' returned no 'hits'. A second search using the key words 'real time' returned 157 hits. However, these related to real time clinical systems and technology. A third search dropping the real time criterion but combining keywords 'patient feedback' and 'patient satisfaction' produced 18 hits. A fourth and final search using 'consumer feedback' produced 84 hits.

Second, a search was undertaken using a combined business and law database consisting of Business Source Premier (EBSCO), Applied Social Sciences Index and Abstracts (ASSIA), Web of Science (ISI), Medline, Periodicals Index Online (Proquest) and Criminology Sage (CSA), with the purpose of searching for examples from industry and commerce outside of the health and social care sectors. Key phrases: customer feedback and customer feedback - good practice were used, returning 154 hits and 73 hits respectively. Of the 227 hits, a number of papers were unavailable in full text due to the type of document e.g. conference paper, company report or newsletter or unpublished thesis. Of the remaining papers a number were not relevant to this study as they did not discuss ‘real-time’ feedback methods or processes. In addition a number were health service related examples. Of the remaining papers, 11 offered some relevance to this study.

A brief summary of the key themes from relevant articles and case study examples are provided in Appendix A.

3.2 Ipsos MORI report: information patients need and value

As part of its work for Project 4, the SHA also commissioned MORI to undertake a study into the information patients think it is important for healthcare organisations to collect, analyse and publish in order that this may inform patient choice and improve satisfaction. Through this study MORI aimed to ‘establish, for each NHS sector, the points in the care pathway where information could/should be captured’ and ‘to understand the most effective and useful methods to gather, analyse and disseminate real time information.’ (MORI 2008)

3.3 Semi-structured telephone interviews

A series of semi-structured telephone interviews were conducted with a number of organisations which were chosen as a result of an initial data collection phase, case study search and networking to scope what is currently happening in this field. The breakdown of these interviews is given in the table below.

Table 1: Number of organisation interviewed

Type of organisation	No of interviews
NHS Provider	5
NHS Commissioner	5
NHS other	3
Private sector	3
Other public sector	3
Technology supplier	5
Total	24

Two further private sector companies were approached but declined to be interviewed due to reasons of market sensitivity.

3.4 Questionnaire and follow up telephone interviews

A questionnaire to assess progress made in the development of such systems and methodologies was issued to every PCT and provider organisation within the West Midlands, and a number of provider and commissioner organisations outside of the SHA area which had demonstrated some progress in this regard – 70 organisations in total. For those organisations within the West Midlands, questionnaires were issued to the Patient and Public Involvement (PPI) Lead for each provider organisation and to both the PPI Lead and Director of Commissioning within each PCT.

Questionnaires were issued to 16 of the 17 West Midlands-based PCTs (one had already been the subject of a semi-structured telephone interview and therefore did not receive a questionnaire to complete). Fifteen were duly completed and returned (though two each were returned from two PCTs). This relates to a West Midlands PCT organisational response rate of 81%. Forty questionnaires were also issued to provider trusts within the West Midlands, of which one was returned. Of the additional 14 sent to organisations outside of the West Midlands, four were returned.

A small number of further contacts were made with specific respondents for clarification of the information provided or to elicit additional information.

A copy of the questionnaire is included as Appendix B.

4 Findings

4.1 Engaging people and soliciting feedback

4.1.1 Response rates

Response rates are falling across all forms of traditional research methodologies (Brennan et al 2005, Comley 2008). In terms of providing feedback to public service organisations, various reasons have been proposed to explain this trend. These include consultation fatigue among local communities; public cynicism about the impact of involvement; and a general decline in civic participation, which is most clearly demonstrated by falling electoral turnout (e. g. Smith, 2005).

Alongside this declining interest in providing feedback, there is considerable evidence that response rates vary among different groups. For example, certain groups are significantly under-represented in the NHS national patient survey - a major source of information on the experience of using health services. According to the Picker Institute, response rates to patient surveys are lower among older

people, younger adults, people from black and minority ethnic (BME) communities, men, those in poor health, people with disabilities, people on low incomes, people who live alone and people with a lower level of education (Sheldon and Rasul, 2006).

Low response rates are not only problematic in terms of the data validity but can lead to bias if the views and experiences of responders differ from those of non-responders. Various strategies have been proposed to encourage survey completion among BME groups, such as targeted information introducing the research; use of specialist media and community organisations to communicate with BME service users; and emphasising the confidential nature of the survey (ibid).

4.1.2 Methods to engage people and solicit feedback

It is apparent that NHS organisations currently employ a vast range of different, and in some cases innovative methods for engaging people to try and address these issues. Methods employed include:

- **Traditional methods** such as annual patient questionnaires, ad-hoc postal surveys, service feedback or evaluation sheets, comment cards and focus groups;
- **Opportunistic methods** such as contacts made through Patient Advisory and Liaison Services (PALS), community engagement events and patient forums; and
- **Innovative methods** such as membership panels, websites, mystery shopper programmes and patient stories.

Two PCTs contacted for the purposes of this study have started to use the concept of social marketing⁶ and segmentation⁷ to consider how best to engage with certain demographic groups of the population and how to gather data. Another PCT is training lay people from within specific communities to act as researchers, while another uses a network of community-based Neighbourhood Health Development Officers to feed back views and comments from local people. It is apparent from respondents that preferences in terms of language are already being taken into account. One PCT, responding to the questionnaire noted its use of translated versions of a survey administered by hand-held devices.

In terms of the methods people state they prefer Ipsos MORI (2008) report that many people still rate a paper questionnaire as the preferred choice, though some believed collecting information over the telephone may improve response rates

⁶ Social marketing – Health-related social marketing is ‘the systematic application of marketing, alongside other concepts and techniques, to achieve specific behavioural goals, to improve health and to reduce inequalities

⁷ Segmentation - The process of splitting customers, or potential customers, in a market into different groups, or segments, within which customers share a similar level of interest in the same or comparable set of needs satisfied by a distinct marketing proposition.

and would be more environmentally friendly. The majority of patients and service users however wanted to see a variety of methods to maximise accessibility and participation.

According to a Scottish survey of people's preferences for different methods (Entwistle et al 2003), this will depend on the nature of the feedback and whether it is a complaint, a general comment or suggestions for improving services. There was a general preference for anonymous systems as people expressed reluctance to voice concerns openly for fear of compromising their care. Although participants in the survey welcomed a range of methods to suit personal needs in principle, they were aware of the potential cost implications of doing so in terms of capital and human resources and raised the issue of prioritisation.

For patients and service users, the availability of information from other patients is seen to be authentic, genuine and practical. According to MORI's research, most patients said they would welcome the opportunity to provide feedback on their own experiences, in order to benefit others. 'Patients indicate that a key component of their enthusiasm for patient feedback is the power they are given to improve things for future patients' (Ipsos MORI 2008, p53)

This has also been the experience of **Thinkpublic Design Company** - an organisation that has worked with a number of NHS organisations (largely through NHS Institute commissions) to capture patient experience and use this to co-design changes to service delivery, known as Experience Based Design (EBD).

According to the company's Director, Deborah Szbeko, the organisation's interventions 'create a culture whereby patients are given permission to contribute and suggest changes and that this can prove extremely motivational - giving people a sense of purpose to make a difference for others.'

Given the relationship between feedback methods and the engagement of people, providing a range of methods and opportunities to solicit feedback is recognised as an important element for an engagement or communications strategy by organisations. It is universally acknowledged that no one method will reach every section within the community and no one method is suitable or preferred by everyone.

In determining methodologies, organisations recognise that they will need to bear in mind the functional literacy and cognitive ability of respondents, so that translated materials or interpreters may be required for those for whom English is not a first language and visual or audio methods may be more suitable for people with low literacy, learning disabilities or sensory impairments.

The Skills for Life national survey carried out in 2003 found that 16% of adults in the UK lacked basic literacy skills, and 47% lacked basic numeracy skills (Department for Education and Skills, 2003). Considerable research has been conducted into the comprehensibility of health information, which may be

instructive here. Studies consistently report that health information developed for patients and the public is written at an above average reading ability, making it difficult for many people to understand (Coulter and Ellins, 2006). It is possible, although not yet proven, that standard approaches to gathering patient feedback are similarly pitched at a reading level which is too high for some.

Box 1: Key points: Engaging people and soliciting feedback

No one method of collecting feedback will reach every group within the community and no one method is suitable or preferred by everyone.

All the organisations contacted provided information that confirmed patient or service user and public feedback was important and valuable to them. This kind of feedback is also seen as highly valuable by other patients and service users.

A key component of patient enthusiasm for feedback is the power they are given to improve things for other patients.

Providing opportunities to give feedback is not an end in itself. The exercise is only as good as the action that is subsequently taken.

4.2 Current practice in designing and undertaking survey feedback

In this section we discuss a number of technical, administrative and organisational practice issues relating to data collection and feedback.

4.2.1 Survey design

An often made criticism of patient feedback surveys is that their focus and content has traditionally been determined by managers or researchers, rather than by patients. This problem has been worked with to some degree in the national patient survey programme as the design methodology starts with issues which patients report matter to them the most. Broadly this methodology involves:

- Consultation with subject experts
- Literature reviews on the topic of the questionnaire
- Focus groups and in-depth interviews with patients and their families
- Drafting of the questionnaire
- Cognitive testing with patients to evaluate and refine the draft questionnaire
- Pilot testing
- Validation studies.

It is possible that patient expectations and priorities change over time, so survey instruments (and other feedback methodologies) should not be developed 'for all time'. Rather, as has happened with the NHS patient survey programme, follow-up research should be conducted to establish whether the aspects of care that are addressed remain relevant and important to patients (Boyd, 2007).

One PCT reported in its questionnaire response that it involved service users in defining appropriate questions for its provider services' patient satisfaction surveys. In a response from an acute trust, outside of the SHA, the importance of asking the right questions and basing these around what matters most to patients was also noted.

However the content of a questionnaire is determined, it must be formally tested to ensure validity and reliability with an iterative design process built in to change questions as experience dictates.

4.2.2 Sampling

Evidence suggests that all survey methods suffer from self selection to some degree or another and therefore samples arrived at by whatever means will produce different outcomes as the profiles of respondents will be different. (Schillewaert and Meulemeester 2005)

Of all respondents to an online questionnaire on patient satisfaction, hosted by a provider organisation, 52% of respondents were female, 33% were male and 15% did not specify. During the same period, 79% of respondents were white British. This sample may be representative in terms of the gender and ethnic origin of patients or visitors etc who could potentially have completed the questionnaire though the baseline data was not available. However, this may also demonstrate that white females are more likely to complete an online questionnaire than men from BME communities. (Sheldon and Rasul 2006)

A question as to whether an Equality Impact Assessment (EIA) had been undertaken by organisations in order to understand the implications of using different methodologies for different groups of people was not asked in this study. However, one acute trust reported that it had undertaken an EIA prior to introducing patient surveys using hand-held devices on its wards.

One PCT noted that a large proportion of its population was functionally illiterate and that it had to provide additional assistance to people to overcome language and technology barriers, such as providing support workers in order to gain feedback. The same PCT also noted that paper-based methods continued to be the most appropriate for it to use due to the demographics of its population.

Another PCT, outside of the West Midlands area, made the point that it experienced particularly poor response rates to the paper-based annual patient survey, largely it felt, as a result of the local population's demographics (50% of

the population is under 26 and there is a high proportion of residents from South East Asia and Eastern Europe).

4.2.3 Systematic processes

Most of the organisations contacted for this project noted that while they collected large amounts of patient and public feedback, this was not collated or analysed systematically and in the main, its use was ad-hoc rather than focused on a specific strategy.

Research on the effectiveness of using survey data in healthcare, is limited but it has been shown that its use is less successful when there is no formal strategy or processes in place. (Davies and Cleary 2005)

4.2.4 Timing of data collection

A number of respondents suggested that while timely feedback is useful for driving improvements at the service level (provider organisations), the provision of information over a longer time-frame may be more suitable for strategic market management decisions (commissioner organisations).

According to the Ipsos MORI report (2008), while some patients preferred to be asked retrospectively for their views on their experience of care as this was considered less intrusive and allowed time for reflection, others were happy to be asked at the point of care, as their experience would be fresh in their minds. Participants in the study did note however that people should only be asked for feedback when they are feeling well enough to do so. Most however felt it was important to allow people choice not only as to the method of feedback collection but also the timing.

Patients and service users also suggested that feedback should be collected at several points within their contact with services in order to highlight differences in experience at particular stages. It is also worth bearing in mind that if patients or service users are evaluating their care at the point of delivery, they will not always be able to comment on the full continuum of the patient journey i.e. discharge arrangements, outpatient follow up appointments, district nursing care etc.

Research suggests there is a U-shaped relationship between the length of time after an episode of care and patient satisfaction i.e. satisfaction may be high initially, then drop, then increase again (Lalonde et al 2001). Ratings will potentially therefore be different at different stages of a patient's or service user's journey. This may be related to how well people feel after their episode of care and whether they feel they have recovered as they would have hoped, so that satisfaction may reduce at some point after an episode of care if people do not feel they are making good progress towards recovery.

Box 2: Key points: Current practice in designing and undertaking survey feedback

Feedback survey design is often determined by managers or researchers, rather than by patients.

Organisations should involve patients and the public in determining what is important to them and therefore what should be measured, bearing in mind that measuring satisfaction alone will not necessarily provide the sort of information an organisation can act upon to effect change.

Questions asked in surveys are often the wrong ones and do not collect the data required; this is usually down to poor skills and a lack of knowledge in asking the right evaluation questions.

In order to maximise response rates, increase representation of the population as a whole and avoid sampling bias as far as possible, organisations will need to employ a range of methods to gather feedback.

The timing of data collection is a critical aspect to ensure organisations use feedback effectively. Data collected at different times will potentially provide different responses.

When it comes to service and quality improvements, the ‘fresher’ the information, the more effective it can be. However when it comes to gathering feedback for long term strategic purposes, the timing of data collection is not necessarily as important as ensuring it is collected on an ongoing basis from a representative sample of the population and is used systematically and according to a clearly defined strategy.

Organisations are spending a considerable amount of time and resources on gathering data. While some organisations are using this information to good effect, this investment nevertheless risks generating a poor return if they do not approach this in a systematic way.

To both ensure effective use of feedback and action taken, organisations need to ensure that they develop a formal strategy and organisational processes for co-ordinating data collection, collation, analysis and dissemination.

Where the responsibility lies for gathering feedback and analysis, reporting and taking action, needs to be clear and understood by all within the organisation.

4.3 Issues to consider when using real-time or near to real-time feedback

There are a number of examples of ‘real time’ methodologies already being employed within the sector as follows: surveys undertaken via kiosks or hand-held devices, website questionnaires, vote boards on websites, polling using hand-held devices, ‘mystery shopper’ programmes, patient diaries, citizen panels, comment cards, and pen and paper questionnaires. The most common methods used are surveys or questionnaires administered through the use of hand-held devices at the point of care. These methods and their use are discussed in detail from Section 4.5.onwards. The use of these methods has raised a number of general points which are discussed below.

4.3.1 Clarity of purpose

Any organisation undertaking to use real-time methodologies and systems must be clear about its purpose for doing so and how and where it fits into its overall strategy for patient and public engagement and involvement.

Surveys of patients at the point of care tend to value speed over and above methodological rigour. This may affect the purpose for which they have been implemented. Evidence suggests that if the goal is to gather feedback or gain general information; to offer every patient or service user that wants it the opportunity to feed back; or to identify those individuals whose experience has been poor, a brief questionnaire would be sufficient. However, if the goal of an organisation is to measure quality with reliable and valid indicators, it will need to employ more robust methods of gathering data in order to achieve truly representative and larger samples with increased response rates and hence to ensure results are statistically significant. (Nelson et al 1991) This may mean the use of mixed methodologies to reach different demographic groups and chaser follow-up letters, emails or phone calls to people who have not provided feedback at the point of care.

4.3.2 Ease of use

Although real-time technology such as hand-held devices, touch screen kiosks and web-based questionnaires are all designed to be as user-friendly as possible, some groups of patients and service users will nonetheless find certain kinds of technology difficult to use and will either require alternative methods to be made available to them or assistance to use the technology.

The elderly and frail may find hand held devices difficult to use comfortably and the text on them may be too small for those with poor sight. People with visual difficulties may require Braille versions or text to audio versions, while versions of the survey in other languages may be required, when English is not a first language. Thought should also be given to the use of technology by other groups such as children and those with physical or learning disabilities.

4.3.3 Positivity of response

Point-of-care surveys appear to produce more positive results than traditional methods. As an example of this, the Health Care Commission undertook a survey of acute trusts regarding hospital acquired infections in 2005. Some surveys were distributed to patients in hospital using hand-held units and others were distributed to patients after discharge in a paper format. Responses from the 'real-time' survey were significantly more positive i.e. resulted in higher quality or satisfaction scores than those from the paper-based survey.

There might be various reasons for this as follows: patients fear a negative response could compromise their care (Ipsos MORI 2008); patients may want to be optimistic about their care while they are receiving it; patients' opinions about their care may not form fully until afterwards when they have had an opportunity to reflect and compare with others who have had a similar experience.

The literature suggests that the results of questionnaires or surveys administered by individuals (as opposed to 'self-interviewing') may be more susceptible to social desirability bias – in that people provide the responses they think the 'researcher' wants (Duffy et al 2005). Furthermore, research by Staniszewska and Henderson found that many patients found it difficult to express and share negative feedback (2004). They reported that "Patients needed to be supported and reassured in voicing their evaluations, and to be given an opportunity to provide a rationale for their evaluations." This suggests that standardised approaches to measuring patient experience – such as questionnaires – may not be the best way of capturing negative feedback. Rather, patients may be more likely to disclose any problems in the delivery of their care when the feedback approach is less direct and more qualitative.

Further work by the same researchers found that patient evaluation was influenced by various factors including gratitude, faith, luck and equity (Staniszewska and Henderson, 2004b). The outcome of these factors was that many patients gave positive evaluations, even when their care was poor. The authors suggest the extent to which patients felt that they were engaged with the health care system may be a better indicator of quality.

However the experience of using hand-held devices for inpatient point of care surveys at one acute trust, outside of the West Midlands, suggests no significant difference in positivity between the real-time survey results and annual patient survey results. The experience of another out of area acute trust which uses hand-held devices for inpatient surveys as well as paper-based comment cards, which can be completed at any point and are completely anonymous, also suggests that there is no difference in positivity between the two methods.

4.3.4 Staff attitudes to patient and public feedback

The value of patient feedback is not universally acknowledged by staff, particularly clinicians. There is no published evidence that feedback leads to sustained improvements (Davies and Cleary 2005). A randomised trial providing

patient survey results to 55 GPs in the Netherlands (Vingerhoets 2001, cited in Davies and Cleary 2005) found no effect on patient evaluations of their care a year on. The study found that the GPs found it difficult to use patient evaluations and ultimately became sceptical of their value.

The view of those using real time methods is that staff feel different about immediate feedback, that it makes it more 'real' to staff which in turn makes it easier for them to own the process and to take responsibility for making changes. However, this requires both a supportive environment from the organisation and a receptive attitude from staff, which may mean a significant culture change within many organisations.

Davies and Cleary (2005) suggest that qualitative data may be viewed more positively than quantitative data by clinicians who often query the statistical significance of the latter. A case study from a US teaching hospital on the use of patient feedback suggests that repeated exposure to patient feedback can alter ingrained clinical attitudes and behaviour. (Tasa et al 1996)

South Birmingham PCT has developed its Share to Care Programme as a means to encourage its providers to value and act upon patient and public feedback. The programme has established a number of problem-solving workshops with a range of providers, including GPs, to work through the issues of using feedback and to develop metrics that can be used to measure patient experience. As a result of the above, providers, including a number of GP practices, have volunteered to take part in a pilot project to focus on how feedback is obtained, how it is acted upon and how responses are shared with patients and the public.

4.3.5 Time delays

Evidence points out that a significant delay from data collection, to feedback, to intervention, will affect how well an organisation can use its feedback from patients, service users and the public. It is also difficult to determine what actions or interventions, if any, have had an effect on improving performance, as other factors will come into play over longer periods of time (Davies and Cleary 2005).

An acute trust within the West Midlands has introduced real time methodologies for just such a reason, citing an example of a previous infection control postal and telephone interview which took three months to produce a report and longer to reach clinical areas, by which time corrective actions had already been taken and things had moved on.

4.4 Products and suppliers

There are a huge number of market research companies in the UK who provide a range of services including questionnaire and survey design and analysis, mystery shopper programmes and focus group facilitation. However there are a limited number that operate specifically in the healthcare market and only a handful that

provide a total solution in terms of hardware, software and management reporting services. The main suppliers in this regard are Dr Foster, The Picker Institute and Customer Research Technology (CRT).

Dr Foster's healthcare product, the Patient Experience Tracker (PET), was introduced a couple of years ago. This is a hand-held device which provides its customers with a five question multiple-choice questionnaire. Data from the PET is gathered and uploaded automatically. Dr Foster carries out the analysis and reporting of responses and reports are emailed to customers on a weekly basis. Results are also provided on-line. The cost per annum for an organisation using 10 devices is £16K.

Dr Foster has a bank of 700 questions that organisations can choose from, though customers can also determine their own. The handsets can be adapted for larger type and Braille and other languages (translations of questions can be provided in 21 languages). The handsets can also be adapted for pictures and smileys. At present Dr Foster is currently working with 16 PCTs, 42 acute hospital trusts, 8 mental health trusts and one GP practice. Of those organisations contacted that provided the name of its supplier, ten use Dr Foster's products.

The Picker Institute's Frequent Feedback service also uses hand-held devices (PDAs) to administer its electronic surveys in conjunction with its technical partners - fr3dom. Results from the surveys are updated each time data is sent from a device and can be viewed immediately by the customer via a secure server. There is greater flexibility in terms of the number of questions that can be loaded onto the devices with some organisations employing over 20 questions. Demographic data can also be collected via this system. Of those organisations that provided the name of its supplier, three are using the Frequent Feedback service. The cost of the service is £20k a year.

CRT provides a range of products, both hand-held, touch screen kiosks and online questionnaires to administer its 'Viewpoint' feedback system which was introduced to the healthcare market two years ago. CRT has also been the sole UK distributor of the American product Opinionmeter, though it is phasing this out now as it develops its own products. The Viewpoint system allows for the use of questions and free text. It is capable of capturing demographic data, though in the supplier's opinion this is not routinely done by users.

CRT has not yet produced a version in Braille or which uses images, though it does provide devices in a number of languages and can direct people using a standard device through to questionnaires available in a number of languages. The majority of CRT's customers buy the hardware and pay an annual licence fee for the software and hardware (up to 10 users). The majority of CRT's customers who use Viewpoint on an ongoing basis do so as a kiosk solution, rather than mobile hand-held devices.

None of those organisations contacted, who named its supplier, used CRT. However, information provided to HSMC lists 30 NHS clients, though these may not all be using the technology on an ongoing basis. As well as healthcare customers, CRT provides the same technology to customers such as Leicestershire Constabulary, Cadbury World, London Underground and Southampton City Council.

Box 3: Key points: Issues to consider when using real time or near real time feedback

The gathering of real-time feedback can bring clear advantages to an organisation. However, it should be clear from the outset where real time fits into its overall strategy for gathering and using feedback.

Real time can increase the chances of feedback being put to effective use as staff recognise the ‘freshness’ of the information and perceive it as having greater validity. Staff particularly appreciate receiving feedback in the patient or users own words as this makes the comments more ‘real’ to them.

The advantages and disadvantages of quantitative and qualitative feedback should also be considered.

By effecting immediate changes, based on real-time data, it should also be possible for organisations to better understand what actions have had what specific effect.

Organisations will need to take into account the needs of all potential users when considering which technology it may wish to introduce.

All of the above should be considered carefully before organisations make an investment in real-time technology or services.

4.5 Current use of ‘real time’ methods and technologies

4.5.1 Face-to-face interviews/patient stories

Research into the lived experience of patients or service users has often used descriptive narrative, gained through an in-depth semi-structured interview with patients or in some cases their relatives and carers. Known as patient stories, the richness of data gained through these qualitative methods can be invaluable for quality improvement purposes. Patient stories can be undertaken either reflectively or in real time, or near to real time terms. The Royal College of Nursing (RCN) who developed the patient stories methodology has shown this to be instrumental in developing effective clinical leaders as well as improving services (Large et al, 2005).

Thirteen organisations responding to the questionnaire, or contacted by telephone, report the use of patient stories as a means of soliciting feedback. Four of these were acute trusts, nine were PCTs.

This method requires time and training and can therefore be more expensive than other methods. The cost can be reduced significantly if volunteers are used to conduct the interviews, though the richness of data on clinical matters may suffer as a result if the interviewer is not familiar with these matters and is unable to probe for detailed responses. One mental health trust in the West Midlands trains ex-service users to conduct exit interviews with older people who have received inpatient care. In keeping with MORI's findings (2008), this approach has been welcomed by service users and may encourage a more honest level of disclosure than those interviews conducted by staff or others seen as associated with the organisation, including regular volunteers.

Because of the time taken to carry out these interviews (half an hour to an hour is considered reasonable), the number of responses is lower than those for surveys administered through hand-held devices which can take just a matter of minutes (organisations report surveys by these means take approximately 10 minutes to complete.) However, one of the advantages of a face-to-face method is that the reasons why issues are being raised can be explored in order to improve services. Technology-based methods in comparison tend to only gather opinions and trends i.e. that 'what' in terms of issues.

Organisations employing face-to-face methods should take into account the moderating effect of an interviewer's presence on responses. Evidence suggests less reporting of personal, emotive or sensitive issues such as substance use through face-to-face interviews and more susceptibility to social desirability bias. (Bronner and Kuijlen 2007; Duffy et al 2005; Wright et al 1998) In order to overcome these limitations some quite subtle questioning will need to be employed when patient stories are used, to solicit responses that address both positive and negative aspects of care.

It has been reported that US and Australian hospitals use patient representatives (PRs) to listen to and solicit feedback from patients. (Entwistle et al 2003) In their study of public opinion into methods for providing feedback, 80% of respondents said they were positive about the use of PRs, with older people more likely to prefer this method. Participants thought PRs would be independent and objective, on the patient's side but nonetheless knowledgeable about health systems. Participants thought PRs would be most useful in providing immediate help to people who are experiencing problems and to drive local quality improvement.

Many acute trusts in the UK use a similar but informal approach with PALS volunteers. These volunteers often sort out many day-to-day issues for patients on the spot. This informal network is a potentially rich source of informal

feedback, and subsequent learning for organisations. One PCT questionnaire respondent also noted it was training lay people to undertake a broadly similar role in the community.

The high positive response rate to the concept of PRs acknowledges that the human touch is important to people and is particularly appreciated at specific times of distress or difficulty. Certainly, there is a strong link between the communicative aspects of care and patient satisfaction. (Clever 2008) There may well be trade offs in using face-to-face methods between addressing people's desire for personal interventions and the risk of losing more sensitive or negative data. The literature also suggests that the restriction of a survey to any mode other than face-to-face would exclude distinctive sub-groups of the population (Blyth 2008).

Box 4: Key points: Face to face methods

Face-to-face methods are likely to be the most inclusive.

People like face-to-face methods for gathering feedback and they are effective for following up on why issues have been raised and what could be done to address them.

However, these methods are time consuming, so will not generate the greatest number of responses in any given time period, require an investment in training and can cost a considerable amount to administer when the 'researchers' require reimbursement or where front-line staff are taken away from their day-to-day activities in order to act as researchers.

Qualitative methods such as these can be an extremely rich source of data; however organisations need to take into account the moderating effect an interviewer's presence can have on responses.

4.5.2 Paper-based methods

Paper-based methods may include pen and paper questionnaires, comment cards or feedback forms. Paper questionnaires normally provide respondents with either multiple choice type answers, or ask people to rate services, or experiences, on a numerical scale such as the Likert scale. In this context, there is usually little opportunity for providing free text or expanding on responses so this method is only likely to identify trends and is best suited for quantitative analysis. Comment cards generally provide respondents with the opportunity to provide complaints or compliments, generating some qualitative analysis. Both can be anonymous if required.

Of those organisations contacted, nine organisations reported the use of paper-based methods for collecting real-time feedback.

Paper-based questionnaires are being used by organisations to solicit real-time feedback as well as reflective feedback (i.e. provided within a short time after care episodes). Where questionnaires are sent out to people to complete retrospectively, the difficulties of a speedy response and acceptable response rates are well documented. (Breen et al 1992, Morrison et al 2003) Response rates can be improved however by employing systematic follow-up methods. (Nelson et al 1991)

Like other self-administered methods, paper-based questionnaires can provide better responses for sensitive questions as they avoid the effects of social desirability. (Blyth 2008; Wright et al 1998) Evidence suggests questionnaires via postal methods generate older respondents and those of a lower educational standard and are more likely to be classed as blue collar. (Schillewaert and Meulemeester 2005)

Though Blyth (2008) suggests a lower item non-response rate in pen and paper methods, Wright et al (1998) conversely note that non-responses and data errors are higher by this means. The latter also observe that pen and paper methods limit the complexity of the questionnaire i.e. use of question branching etc. Nelson et al (1991) note that the briefer the questionnaire, the higher the response rate.

Respondents in Entwistle's survey (2003) observed that feedback forms were easy and convenient to use and would allow people to provide feedback in a non-confrontational way. They also noted that the very existence of such forms suggested the organisation took their feedback seriously. The literature suggests however that complaint/compliment systems such as comment cards are valid but unreliable as they produce extremes in responses. (Tasa et al 1996)

Case studies – paper-based methods

A UK independent healthcare company which currently has 32 hospitals (31 in England and one in Scotland), uses a patient satisfaction sheet to gather feedback from inpatients. The sheet is handed to patients when they are admitted. A ward receptionist collects these before the patients go home, though patients can also complete the forms at home and post them back. All feedback forms are sent to a central collection point. They are then sent on to a third party for collation and analysis.

Jury's Inns use comment cards placed in bedrooms and handed out when guests check-in and check out. (In addition, the company asks people who have booked on line (approx 15% of total bookings) to complete an online survey which generates a 35-40% response rate.) The questionnaire includes a mixture of rating type questions and free text. All comments are collated and analysed centrally, though specific comments about individual hotels and their staff are dealt with at

hotel level. Each hotel also responds to every individual who has completed a questionnaire or comment card by either email or phone. From trends identified corporately, the organisation has implemented changes such as healthier options for breakfast. Customer feedback and the actions taken as a result are posted up into staff canteens.

Another UK-based hotel chain uses comment cards left in bedrooms for every new guest – this is one of the organisation’s core standards. The same questions are asked at each hotel regarding cleanliness, service, staff attitude etc but each has the discretion whether to offer an incentive for guests to complete a card i.e. guests are entered into a raffle to win dinner for two etc. In October 2008 the organisation received 2,500 comment cards – approximately 60 per hotel.

Each hotel’s data is collated centrally to produce monthly board reports. Each hotel responds individually to every guest who has completed a comments card, whether by phone call or letter. Complaints are responded to within 24 hours by each hotel’s general manager. As a relatively small group, the organisation prefers to manage customer feedback in-house. It has also operated a mystery guest scheme for four years using existing and valued residential and business customers. Feedback from guests has resulted in a number of changes such as the refurbishment of specific hotel areas and the incorporation of a £2 credit card charge into the standard room rate.

Box 5: Key points: Paper based methods

Paper-based methods are cheap, convenient and generally user-friendly, depending on a questionnaire’s length and complexity.

It is possible to obtain large volumes of quantitative data though the use of paper-based methods for gaining qualitative data is limited.

Postal questionnaires result in poor and slow response rates, though these methods are favoured by certain groups of the population, such as older people and those of a lower educational standard.

Self-administered paper-based questionnaires can result in higher reporting of undesirable or socially unacceptable behaviour.

Comment or feedback cards can result in the reporting of mostly extreme responses.

4.5.3 Hand-held devices

PDAs (personal digital assistants) are increasingly being used for gathering real-time feedback. These hand-held computers typically have a touch screen or soft keys for entering data, a memory card slot for data storage and connectivity to

enable the downloading of data directly to a computer or through a phone line. Questionnaires are loaded on to these units which are then handed out to patients and service users to self-administer, where possible. The size of the device can vary from product to product, with some as small as a mobile phone and others as large as a laptop – often referred to as a tablet.

Of those organisations contacted by questionnaire and telephone, 17 are using or have used hand-held devices. Of these, nine are acute trusts and eight are PCTs. In acute trusts, hand-held devices are being used to undertake regular surveys on wards and in outpatient clinics. Of the PCTs, six have used hand-held devices at least once for specific events in order to gain the opinions and views of those attending. These include public meetings and workshops where the devices are used to provide attendees with the immediate results of people's responses to specific questions – deliberative polling. Four of the PCTs are using the devices in their own provider arm, either within community clinic settings, GP practices or by particular staff groups such as District Nurses.

Within an inpatient setting the sample of respondents is largely determined by the nursing staff who decide which patients are well enough to take part in a survey using hand-held devices. Overall responses could be increased if those patients, who are not able to complete the survey using a hand-held device while on the ward, are provided with another means to complete the same questionnaire retrospectively.

As the number of people able to be treated by day surgery increases, it is possible that the profile of inpatients will change, so that the proportion of those people on the ward who are less well increases. This may therefore have an affect on the maximum response rate. Acute trusts should therefore be mindful of day surgery as an equally important area in which to establish surveys, particularly as the demographic mix may be rather different.

The number of questions which can be asked using a hand-held device varies considerably between systems and users. Dr Foster's Patient Experience Tracker (PET) only allows for five questions to be asked while both the Picker Frequent Feedback and CRT Viewpoint products provide for a much larger range. CRT advises its customers to use 9-15 questions as a maximum and to present them in a chronological order based on the patient journey from arriving, to admission, treatment and discharge. One acute trust uses a 25-question survey with Picker's system while another acute trust, started with 20 questions in its survey but has subsequently reduced this to 15 questions.

Survey questions are generally chosen as a result of issues flagged in the national patient survey, though in some organisations a number of questions may be left to individual wards, services or areas to determine as most appropriate for their service users i.e. a question regarding pain relief for post-operative patients. The surveys are typically administered by trained volunteers. Where possible, volunteers will simply give the device to patients with instructions, allowing them

to complete the survey on their own. Where this is not possible, the volunteers will assist a patient to complete the survey. One organisation has also provided its volunteers with feedback cards to capture additional information which may not be asked for within the surveys but which is nonetheless provided by the patient.

One acute trust contacted is currently receiving 100-150 responses a month but wants to achieve 30 a month in each care group to make the results meaningful and to be able to drill down to ward level. Another has so far received 100 responses a month on average during its pilot project. Where a PET device has been employed by a PCT's District Nursing service 1697 responses were collected in six months – an average of 141 a month.

Case studies – hand-held devices

Bradford & Airedale PCT hired 200 devices for a two-day consultation event on the NHS Constitution in October. The PCT is now considering purchasing its own devices for similar use in the future and is looking at a number of options. The flexibility to vary questions frequently and quickly is important to the PCT in order that it can respond to specific issues that may be raised in different ways and to ensure best value. In this way, the PCT would want to use the devices to undertake deliberative polling to gain a wider view of the significance of a specific issue. The PCT has had demonstrations from six companies but none has offered a solution that meets the PCT's needs – the PCT will review its requirements shortly.

Salisbury Acute Trust has just completed a second pilot phase using the Picker Frequent Feedback System, with full roll out from November '08. The Trust decided to employ real-time techniques as the organisation felt immediate feedback would be more meaningful to staff and would foster greater ownership of the issues and responsibility for effecting change.

The first pilot phase involved a 42 question survey which took 20 minutes to complete per patient. Forty-four patients were surveyed over four days. The intention was to use volunteers to administer the survey though due to low numbers coming forward, members of the senior management team took part – which the trust reported as a valuable learning experience. All wards took part in the second pilot phase, which surveyed 75 patients over a two-week period. The number of questions was reduced to 25 and the survey took 10 minutes to complete on average. Questions are based on national patient survey themes.

Salisbury's experience suggests that only 50% of inpatients at any one time will be well enough to take part and this is therefore seen by the Trust as the maximum response rate. The trust anticipates generating a management report once 150/200 surveys have been completed and it expects to achieve this within one month. The Trust does not see any benefit at this stage in producing reports more frequently than monthly as corrective actions, where necessary, cannot

realistically be carried out in a shorter timescale. However, the option to report every week is available.

Management reports will go to the Trust's Clinical Governance Committee, Directorate Managers and ward staff. Eventually, Salisbury would like to develop on-line reporting so staff can access reports for their own areas as and when required. Feedback on the survey results and corrective actions will be provided to patients and visitors through posters put up on the wards and other departments. (These are generated automatically by the system.) Results will also be published on the Trust's website.

Box 6: Key points: Hand held devices

Sample size and the representativeness of that sample within inpatient settings must be properly monitored by organisations.

There is the potential for sampling bias to occur if staff screen out potential respondents for reasons other than capacity e.g. because an individual is likely to provide negative responses or because an individual may be considered a 'difficult' candidate for volunteers because of language barriers or disabilities.

The routine collection of demographic data and monitoring of positive and negative responses should help to provide some reassurance against sample bias, whether the setting is an acute trust or PCT.

The provision of alternative methods to collect feedback from those unable to take part in a ward-based survey is also recommended to ensure high response rates and meaningful results.

Organisations will need to spend a short time training staff or volunteers expected to administer surveys using hand-held devices. Where volunteers are used, this will require some co-ordination in terms of recruitment, training and scheduling.

Where possible, surveys should be self-administered, with patients and service users given privacy to complete in order to ensure anonymity.

Organisations will probably wish to use different questions in different settings and for different purposes. A contract with a supplier which gives maximum flexibility to vary questions, as required, will probably be important for most organisations.

As with any questionnaire, a pilot phase to test out the questions used and to address any operational issues arising from the use of hand-held devices is critical.

4.5.4 Kiosks

A kiosk is a stand-alone touch screen device which is larger than a PDA. They are usually static within a location and can be either wall mounted or floor mounted. They may be placed in GP surgeries or pharmacies or in specific areas within hospitals or clinics. They may also be placed in other locations frequented by the public in large numbers, such as libraries, post offices etc. Organisations may choose this method to seek the views and opinions of a captive audience opportunistically. Respondents can complete surveys anonymously using the technology.

Of those organisations contacted, nine are using kiosk technology – five acute trusts and four PCTs. According to HSMC's research, organisations are using kiosks as an alternative to hand-held devices in locations where a static solution is appropriate such as waiting and reception areas in community clinics and outpatient departments.

One PCT is trialling four different ways of gaining feedback from primary care patients attending one of five pilot GP practices - one of which is a kiosk. The PCT's aim is to gather and analyse feedback within 24 hours of a respondent's attendance at a participating practice. The other methods being trialled are paper-based questionnaires, telephone interviews and online questionnaires. Another PCT has used kiosks to gain feedback as part of a consultation exercise on the future of sexual health services. An acute trust contacted is piloting touch screen kiosks alongside hand-held devices to compare response rates and ease of use.

It is impossible, given that people self-select themselves to participate, to get a representative sample of respondents using kiosks. It is often the extremes of opinion that are provided by these methods and a certain type of individual who will feel comfortable using this sort of technology, which may exclude other groups such as older service users.

There is a growing body of evidence about the use and effectiveness of health kiosks. Much of this relates to their role in delivering health information, but is also relevant to other purposes including feedback. A review of the published literature, conducted on behalf of NHS Choices, concluded that kiosks can be effective but only if careful thought is given as to how they are integrated into the patient experience and the healthcare setting (Jones, 2008). Many studies have shown that an initial burst of interest tends to drop off quickly unless patients are actively encouraged by a member of staff to use the kiosk and shown how to do so. They are most likely to be used when they are multi-purpose – for example, combining patient registration, information giving, feedback systems and other functions. In short, kiosks that act as a 'one stop shop' for patients to complete a number of different activities present the best opportunity for gathering patient feedback.

There is also an issue over the timing of survey completion which can affect how well-used kiosks are. People attending clinic appointments may not want to linger

after their appointment to complete a survey, however short. One acute trust suggested this was a particular problem when people had to consider car-parking charges. In most cases, medical appointments are an interruption to people's daily lives, such that there is often a pressing need to be elsewhere as quickly as possible. People waiting for treatment might be able to comment on general issues such as cleanliness etc but cannot comment on the quality of care provided to them.

There is also some anecdotal information that suggests these units can also be vulnerable to misuse i.e. staff entering multiple survey responses to manipulate positive response rates, or people using them through boredom rather than mischief. However, as responses can be time and date-coded, those that are considered suspect can be identified and discounted.

Case study – kiosks

Medical College of Georgia, School of Medicine in the US: researchers developed a touch screen kiosk for patients to answer questions on their experience with a physician at primary care sites in Georgia. A pilot ran for eight weeks during which time the patient answered six communication-related questions. The patient's input became a colour-coded measure which at two sites appeared on a 24" monitor (or dashboard) at the back of the clinic with red for below average, yellow for average and green for above average. To protect patient anonymity, the monitor only updated with every fifth patient. Feedback about an individual physician was included in private emails to that physician at the end of each day.

Researchers are keen to know whether physicians will change their behaviour on a real-time basis in order to get more green lights. The project is focusing on communication questions as poor communication is considered the number one predictor of malpractice and is at the heart of an increasing number of documented reports and anecdotal information on patient dissatisfaction (Medical College of Georgia 2008).

Box 7: Key points: Kiosks

Kiosks provide an alternative means to complete a survey anonymously and are generally sited in areas of high footfall, where a static solution is appropriate. Organisations must work to ensure that the kiosk is visible, well-maintained and its purpose explained.

Sample representativeness is a serious drawback as people self-select themselves to participate. Though they are generally considered user-friendly, certain groups, such as the less technically literate, are less likely to use a kiosk, especially where there is no ready assistance available.

Time pressures may prevent people from using kiosks to complete surveys.

Kiosks can be vulnerable to misuse.

4.5.5 Bedside terminals

Feedback in hospital environments can be provided via bedside television units i.e. systems such as Patientline. These units normally provide a personal phone as well as radio and television channels and in some hospitals units are provided which can be used to play computer games and can provide access to the internet and email.

It is possible to adapt these units to provide a patient survey, either through touch screen technology or through a phone or online survey, where internet access is available. Where terminals do not have a keyboard the inputting of free text is clearly not possible.

Of those organisations contacted, two PCTs noted that one of its acute providers was using this methodology.

Box 8: Key points: Bedside terminals

This method may overcome some of the problems of sampling associated with hand-held devices handed out to people.

Incentives could be provided such as free credit on the terminals in order to increase response rates. As the cost of using these units is often significant, this could be a very welcome incentive to patients.

4.5.6 Telephone interviewing

Telephone interviewing may take the form of either a self-administered questionnaire, where respondents key in their responses using the phone keypad using automatic voice prompts, or a questionnaire administered by an interviewer. In some cases, informal interviews can also take place using the phone i.e. patient stories. Interviews may be pre-arranged between the interviewer and respondent, or individuals may be called opportunistically. Cold calling using random digit dialling is also a well-used market research technique, to produce a random sample of members of the public. The latter is more likely to be used for soliciting general views and opinions rather than specific experiences of healthcare.

Of those organisations contacted, three noted the use of telephone interviewing (one acute and two PCTs). One of the PCTs had used a market research company to conduct telephone surveys, asking members of the public 'trade off' questions to determine people's priorities for health funding. The results were used to inform the PCT's Local Delivery Plan (LDP).

Home, landline or terrestrial telephone ownership is decreasing however in favour of mobile coverage. According to a study undertaken in 2008 13% of adults over 15 have no fixed line phone (Blyth 2008), while other figures suggest 7% of

households have no phone or mobile at all (Duffy et al 2005), with younger households most likely to have a mobile only.

A comparison of different response rates by methodology (Schillewaert and Meulemeester 2005) showed a response rate of just 35% with random digit dialling. Brennan, Benson and Kearns study to consider the effects of offering incentives to potential respondents to increase response rates found that offering to provide the research results produced no significant increase (2005). Assurances of anonymity actually produced a negative effect perhaps because people thought the survey must have been more sensitive in nature. The offer of a small monetary incentive did increase rates but this is unlikely to be practical in large scale random digit dialling surveys.

Where telephone surveys are conducted, whether administered by an interviewer or by automated voice recognition, the length of a questionnaire would generally be shorter than a paper-based or online questionnaire. The same would be true for Short Messaging Service (SMS or text) responses. There is therefore less opportunity for respondents to provide detailed answers. The evidence suggests that respondents to telephone interviews are more likely to give extreme points on scale type answers but are less likely to give 'don't know' type responses (Bronner and Kuijlen 2007). However, respondents to telephone questionnaires also have less time than respondents to paper-based or online methods to reflect and consider their answers, so responses may not be as considered as those produced by other methods.

Bronner and Kuijlen (ibid) also noted that the presence of an interviewer may pose a moderating effect so that there is less reporting of personal or emotive issues. The phenomenon of 'evaluation apprehension' may also mean that respondents wish to present themselves in a more positive light if they think they are being evaluated in any way.

Contacting patients and service users after a care episode by phone in order to conduct a survey can raise difficulties as numbers (whether land line or mobile) are not universally collected – an address is often all that is routinely collected in terms of contact details. This would also affect an organisations' ability to contact people by text.

4.5.7 Telephone Helpline/Comment line

Some organisations, such as the BBC, provide a telephone line as a dedicated channel for people to call and leave feedback. This may be either automated or answered by operators.

In Entwistle's survey to determine preferred methods of providing feedback, a telephone comments line was considered by participants to be easy and accessible and could be used at an individual's own convenience. It would also have the advantage of allowing for personal interaction. It would however require careful explanation to people through publicity to manage people's expectations

as to what its purpose was and what it could deliver. However a third of participants thought a dedicated phone line for comments would be a waste of NHS resources. (Entwistle et al 2003)

One PCT is using a telephone system for people with long-term conditions. The system provides support to people through advice and guidance but also provides people with the opportunity to provide feedback on their experiences. The PCT is currently looking to develop a similar system for other patient groups.

Box 9: Key points: Telephone interviewing

A distinction should be drawn between telephone interviewing whereby respondents are determined randomly and the call is opportunistic and telephone interviews which are either pre-arranged with the respondent or where the respondent is expecting a follow-up call at some point after an episode of care.

Response rates are likely to be higher with the latter than the former, though for the latter to be effective, organisations must collect contact telephone numbers for patients and service users as a matter of routine.

Where people are contacted opportunistically, telephone interviewing may be viewed as intrusive. However this can be a convenient method for people where an interview is pre-arranged.

Computer Assisted Telephone Interviewing (CATI) can reduce data entries as responses are keyed directly into a computer. Results can be analysed quickly and continuously. CATI is also a cost effective method.

Telephone questionnaires with CATI are usually shorter, would allow for less detailed responses and may not give people enough time to provide well considered answers.

These issues can be redressed where an interviewer is used, though this is a more costly option. The presence of an interviewer however may produce 'moderating results' in people's responses.

The lack of universal coverage for telephone ownership means that the use of telephone interviewing would result in the under-representation of certain groups of the population i.e. younger households and the socio-economically disadvantaged. Therefore telephone interviewing whether computer assisted or not, is best used where precision of results is not required. (Breen, Donnelly, Chalmers 1992)

4.5.8 Online questionnaires

Online methods require a respondent to complete a computerised questionnaire. The questionnaire may either be emailed directly to an individual or people are signposted to a questionnaire on a website.

Contacting patients and service users after a care episode by email in order to conduct a survey can raise difficulties as email addresses are not universally collected as contact details. Signposting people to an organisation's website in order to complete a questionnaire, is therefore often a preferable option. Of those organisations contacted, six are using or have used online surveys (three acute trusts and three PCTs).

Not everyone trusts the information provided on websites or other online methods or the provision of personal information and feedback by these electronic methods (Ipsos MORI 2008). There is a higher likelihood that these methods will be attractive to people who have a positive experience of using computers either at school or work (Wright et al 1998), and may be useful when reaching out to younger patients.

Studies show that computer-assisted self-interviewing (CASI) results in better responses to sensitive questions as it avoids the interviewer effects of social desirability (Duffy et al 2005; Bronner and Kuijlen 2007). For example in one study, disease prevalence rates were considered closer to known rates when using an online questionnaire as opposed to face-to-face or by telephone, while in another study more mental health issues were reported in online questionnaires than by telephone and face-to-face interviews. Evidence suggests adolescents are more likely to report sensitive information by computerised methods than by pen and paper, even when the latter is also self-administered (Wright et al 1998).

CASI allows for more detailed answers to questions, complex routing and the use of graphics and other visual aids. Respondents choose when to respond and have more time to deliberate and reflect – this may result in the reported lower item non-response rate. (Blyth 2008) Evidence suggests respondents are more likely to give mid-point scale responses (Bronner and Kuijlen 2007; Duffy et al 2005) but also more 'don't know' responses (Bronner and Kuijlen 2007).

Evidence suggests however that respondent fatigue is more evident in online surveys as there is no interviewer to give encouragement to complete. The first drop-off rate is considered to be at 18 minutes (Duffy et al 2005).

It is possible to accumulate large volumes of data in a short space of time with online questionnaires but good practice suggests that for a one-off questionnaire, a minimum time period must still be given to ensure good coverage.

The disadvantage of using online methods is the population varies substantially in levels of internet access and use. Since the early 2000s, the percentage of UK households with home internet access has steadily increased and reached 65% by 2008 (Office for National Statistics, 2008). The group most likely to have a home internet connection – 93% in total – is adults under the age of 70 who have a university degree or higher. By contrast, internet access is significantly lower among people who are older, less affluent, who have poorer health, and who have no formal qualifications. (DH, 2005)

According to Blyth (2008), internet use is lower than acknowledged – 64% for 15-24 year old but only 35% for over 55s. These findings indicate that the use of online surveys or other internet-based methods for gathering feedback will systematically exclude certain groups. In many cases, these are the same groups who are least well served by the health service.

The risk is that health inequalities will be widened unless other methods of giving feedback and participation in service development are provided.

Online surveys do however reach the educated and well-off who may not respond as well to other methods, such as cold calling. Those that do respond online are generally better informed than face-to-face interview samples and are more likely to have active opinions (Duffy et al 2005).

Because of the sampling issues, there is a problem with external validation with CASI, especially if the research question relates to a population where the level of internet penetration doesn't match the focal population (Schillewaert 2005). Therefore online questionnaires, like telephone interviewing, are probably only best used where precision of results is not required.

Case-studies - online questionnaire

University Hospitals Coventry and Warwickshire (UHCW) has used a web-based questionnaire called Impressions, since Feb 2007. The provider of the system is Lepidus Ltd.

The questionnaire is advertised both on the Trust's website, under the banner 'Did we get it right?', and on boards around the hospital site. Letters sent to patients prior to admission also encourage people to complete the questionnaire on their return home. UHCW receives 78 responses a month on average. From the comments made in free text sections of the questionnaire, the organisation has concluded that most respondents do complete the questionnaire within a short time after visiting the hospital. Responses are encouraged from patients, visitors, relatives and carers.

Categories such as cleanliness, privacy and dignity, staff attitudes etc are scored out of 10 and free text allows respondents to elaborate if they wish. Verbatim comments are sent to relevant departments on a daily basis. Management reports

go to the Trust's Performance Monitoring Committee and Trust Board. Since April '08, quarterly reports, in a dashboard style, are sent to Coventry PCT.

As a result of feedback the organisation has implemented a number of changes such as a change to visiting times, improved signage and the installation of a water cooler in an out-patient department. It is generally left to the individual hospital divisions to take whatever action is felt appropriate from the feedback received. The Trust thought that staff responded positively to feedback, appreciated the immediacy of responses and liked comments that were given in the patient's 'own voice', as it felt more real.

The system is user-friendly for both respondents and users, with reports generated at the touch of a button. Minimal training is required to operate the system. In terms of investment, an initial capital outlay was required to implement the system, with ongoing annual maintenance and support costs. The Trust is also considering using the same methodology to undertake staff surveys. The Trust does not intend to supplement the web-based questionnaire with a paper-based questionnaire as this method is considered too labour-intensive. It is however considering hand-held devices in the future.

The same product is also in use at two other acute trusts within the West Midlands.

A West Midlands PCT is also piloting the system with its podiatry service and a GP surgery. The PCT is looking to expand the survey across other services but the focus here is on service improvement rather than commissioning.

For the eight-week GP pilot, patients are able to complete the online questionnaire on a PC at the surgery or at home. The supplier is also looking to adapt the questionnaire for a postal version. The questionnaire is advertised by posters in the surgery and via leaflets handed out with prescriptions and at registration. Real value has been seen from the verbatim comments provided by respondents and these are provided back to the surgery on a daily basis. Changes which have been made as a result of the feedback include the installation of water coolers in waiting areas and improved signage.

Box 10: Key points: online questionnaires

The provision of personal information and feedback via the internet will not generate high responses where trust and understanding of technology is low.

Self-administered computerised questionnaires result in better responses to sensitive questions as they avoid the moderating effects of an interviewer's presence.

Computerised questionnaires allow for more detailed answers to questions, complex routing and the use of graphics and other visual aids. Respondents choose when it is convenient for them to respond and will usually have more time to deliberate and reflect. However, respondent fatigue is more evident in online surveys.

It is possible to gather a lot of data in a short space of time with online questionnaires but a minimum time period should still be given for respondents to submit completed questionnaires

Internet coverage is not universal resulting in concerns over representative samples.

Websites

In addition to computerised questionnaires, organisations can employ a variety of other online methods to gather feedback and encourage interaction with customers, service users or citizens. As well as hosting an online questionnaire, an organisation's own website can also provide people with the opportunity to leave general feedback through computerised feedback or comment forms, or to give their views on specific issues through polling.

Eight NHS organisations contacted during the course of this research project expressed an intention to use their own websites more proactively to encourage real-time feedback. One PCT uses voting buttons on its website to gain views on specific issues, while another has just re-launched its website to achieve something similar.

Informal patient and service user feedback is also available on a range of other websites which are non organisation-specific. NHS Choices and Patient Opinion websites both provide people with the facility to feedback comments in the form of ratings and free text on any aspect of care they or their relatives have received.

The purpose of this facility on the NHS Choices website is to provide additional information, including patients' opinions, in order to help people make decisions about which hospital to go to for their treatment. Currently, people can only comment on hospitals providing NHS care. However, from summer 2009, people will also be able to comment on the service they receive from their GP.

These comments are available to NHS organisations and can provide a rich source of data. A number of respondents and interviewees mentioned NHS Choices as a data source with two specifically referring to the systematic drawing in of this information to their own databases.

Patient Opinion is a social enterprise organisation. It is therefore independent and funded by subscriptions from acute trusts and PCTs. This enables subscribers to post responses to feedback left by individuals, request Patient Opinion to run surveys on their behalf and generate reports to compare their feedback with other organisations. According to Patient Opinions website, 7,000 people have posted comments to date (information accessed 13/10/2008).

In addition to these specific websites, a great deal of healthcare related dialogue occurs on social networking and media internet sites. New mothers for example may write about their experiences of giving birth on a variety of forums such as www.newmums.com. Organisations could tap into this additional source of potentially rich data, though it would require investment in the IT systems and resources to do so.

In Entwistle's survey, respondents commented on the ease, convenience and speed of using a website to leave feedback but considered this method would be more useful for feeding back general comments or highlighting trends, rather than specific issues or problems. Respondents also noted that a website would provide people with the opportunity to leave feedback anonymously and avoid direct contact with people if they so wished. Unlike a dedicated telephone feedback line, respondents thought that a dedicated website for feedback would not be a waste of NHS resources (Entwistle 2003).

Online communities

Another method gaining popularity is online communities. These are groups of people whose members communicate with each other electronically – similar to social networking but established for the specific purpose of gathering feedback and opinion on a particular theme or topic. Though largely for qualitative research, quantitative polls can be run through online communities when required. These communities are easier to establish where there is a common interest or concern. They may therefore be well suited to disease specific groups such as people with a long-term condition like diabetes, or groups such as new parents. One PCT contacted is currently testing out on-line communities for condition-related networks i.e. diabetes, in order for people to engage with each other and health professionals.

Research suggests online communities are typically smaller than online panels with perhaps 300-500 members as an optimum number (Comley 2008). To avoid attracting 'the usual suspects', good practice suggests that members are recruited randomly and not via the internet or volunteers (Bronner and Kuijlen 2007). Building online communities is difficult and initially time consuming and requires expertise, regular monitoring and ongoing maintenance to keep

membership updated and replace inactive members etc. Contact is recommended on a weekly basis as a minimum (Comley 2008).

An online community is a convenient approach for people as they choose when to respond. Evidence suggests this increases response rates (Bronner and Kuijlen 2007) Comley's research found that women tend to contribute more frequently, while other evidence suggests those that sign up to online communities in general tend to have a younger and more male profile and are more knowledgeable or 'viewpoint' oriented than face-to-face samples. (Duffy et al 2005)

Online communities may be of particular benefit where feedback is required on an ongoing basis, either for a longer-term project (such as the establishment of a new service or a new capital build) whereby respondents can see what's being changed by the organisation and can continue to provide feedback. In addition, online communities make it easier to keep in contact with people over longer periods of time for longitudinal research. (Schillewaert and Meulemeester 2005)

These communities can generate large volumes of data which can be problematic if the organisation doesn't have systems set up to manage this. The costs of real-time translation into other languages may also be prohibitive so that generally online communities would be single language.

By taking part, members may be subject to *conditioning effects*⁸ and may therefore become less representative of the general population, though the research suggests they may also become more honest in their responses (Comley 2005).

As with other online methods, online communities cannot be representative of the whole population because of the lack of universal internet coverage. As a result, Comley recommends supplementing online communities with other methods. Blyth (2008) also notes that recruiting members from non-home computers may encourage respondents to take actions in contravention of work-based or school/college-based terms and conditions of computer usage.

There is no reliable evidence on computer-based, consumer-led, peer-to-peer communities and support groups in terms of the effects on health and social outcomes. (Eysenbach 2004)

Case Study – web-based applications

The London Borough of Barnet sees web based applications as an increasing part of day-to-day usage for citizens. They are viewed as beneficial because they are; interactive, accessible, transparent, and initiate conversations and communication with customers.

⁸ Conditioning effects – evidence suggests lay people who become involved with an organisation in this way can become more loyal or committed to the organisation

“IT solutions are not seen as rocket science. They help with bringing the customer into the prioritising and decision making processes, push organisations to take actions, and require feedback loops to ensure that there is follow up. However, a key issue is choosing what to do – where to place the investment - as some of the platforms are still very new.”

When asked about use of web-based initiatives, a council employee said that it provided Barnet with a “real challenge as opinion is offered whether solicited or not. The social movement effect meant that this could grow and develop a life of its own and that as feedback was not owned by the local authority it could well be a tool for shaking up local government.”

Barnet utilises a number of different methods for gaining feedback with citizens and customers including YouTube, fixmystreet.com, getsatisfaction.com, Facebook and their own dedicated website: <http://www.wherelive.org/>

wherelive.com provides a place to tell stories about Barnet - about where a person lives, their street, their area, etc. People are encouraged to tell both good and bad stories – what they appreciate and what they would like to change. The site offers opportunities to tell a story, post a picture, upload a video or start a blog.

On the site there are a number of ‘forums’ linked to council services, the environment, safety and crime, etc. which can be used to post stories, messages, videos or blogs. In addition, there are a number of links to other websites for entertainment, activities and feedback for example Patient Opinion.

YouTube is also used by Barnet Housing Department, both to post videos as part of their social marketing strategy as well a space for people to leave video messages, photos, etc. about the service or provision: <http://uk.youtube.com/watch?v=SET81KuyCYI&eurl=http://www.wherelive.org/2008/10/13/video/community-safety-childs-hill>

Currently Barnet is working to develop social media tools, and is targeting its planning department for a pilot sending email alerts to alert and track planning applications. The council is using *Headshift* to support it with this.

Headshift is a leading social computing consultancy in Europe. It has over five years' experience in designing, implementing and growing next generation social software solutions. ‘Social computing’ is - it believes – a method of transforming the way in which business is done. Based in London, Headshift also operates in New York, Paris, Sydney, Rome and Zurich and has a strong network elsewhere in the world.

Its work is focused on delivering smarter, simpler, more social IT solutions internally within large enterprises, knowledge intensive firms, government and third sector organisations. This includes social media practice, with organisations

or networks that want to engage with their customers in new and innovative ways.

Headshift integrates a range of effective products and platforms as well as developing its own custom code to create applications tailored to specific needs. The company works with a number of technology partners including Atlassian, Six Apart, Newsgator, Cogenz, Socialtext and Thoughtfarmer.

In addition, Barnet has worked with **thinkpublic**: <http://thinkpublic.com/news/> to discover what people feel like in two different wards of the borough, one with low crime rates and another with high crime rates. Using video diaries and vox pop, they worked with a group of “borderline ASBO kids” and discovered that there was little difference in what these young people wanted to happen in relation to crime prevention and reduction than for the rest of the population in the wards. The innovative technology used allowed them to access people who would otherwise be hard to reach.

Other sites Barnet suggested were effective for using in this way were:

getsatisfaction.com <http://getsatisfaction.com/>

Get Satisfaction is a direct connection between people and companies that fosters problem-solving, promotes sharing, and builds up relationships. The web based space is used to support customers, exchange ideas, and get feedback about products and services. Get Satisfaction is open, transparent and free. People are free to ask, free to answer, and free to start a new conversation. Everyone is invited and encouraged to participate: companies, employees, customers — anyone with an opinion, an answer, or something to say. This site is used by nearly 3,000 companies most of which are media or IT related. However, there are a few that are different e.g. Northwestern University, a furniture retail chain, Chrysler Car Company and phone companies including AT&T.

mysociety.com: <http://www.mysociety.org/about/> builds websites that give people benefits in the civic and community aspects of their lives. Some of the sites it has set up are linked to:

- Government: <http://www.mysociety.org/projects/theyworkforyou/> to help people work out who their politicians are, and to help them send messages: <http://www.mysociety.org/projects/writetothem/> and to help people get information out of government departments and agencies: <http://www.mysociety.org/projects/whatdotheyknow/>
- Local authority services <http://www.mysociety.org/projects/fixmystreet/> and
- Pledgebank which is a site to help people get things done, particularly where several people are needed: <http://www.pledgebank.com/>

Barnet uses a *Customer Contact System* to collect data from high volume interaction services to the public such as the environmental, planning, transport and street services. Data from this system can be segmented in a number of ways - for example in relation to demography and geography, analysing service demand and showing the peaks and troughs on a weekly basis. Many services have targets

for responsiveness. Data, and emerging patterns and trends, are analyzed and reported on a six monthly basis to the Head of Customer Services in order to inform strategy.

However, the current system is limited in coverage in that it does not cover all high volume services, for example schools and council tax are not included, and areas where there are complicated statutory requirements e.g. social care service users are not all on the system. In addition, it does not provide feedback on satisfaction for all areas of service, although it does record complaints. Barnet is currently upgrading to a Customer Relationship Management System that will cover more areas.

Barnet has also undertaken residents' surveys including:

- Annual Residents Attitude Survey, which is London wide but provides for local questions as well
- BVPI survey, which was a statutory requirement, measuring satisfaction for a range of services, now replaced by the Place Survey, which is more concerned with satisfaction with the local area rather than service provision.

However, as with many local authorities, data is not always used to drive decisions and actions.

Box 11: Key points: Web based and on-line communities

The use of websites to provide feedback is quick, easy and convenient, though this method may be more appropriate for certain types of feedback such as general comments and opinions rather than concerns or specific issues.

Online communities are useful for generating large volumes of qualitative data from people on a specific topic or theme. They are quick and convenient and their use can increase response rates. This method is also useful for gathering ongoing feedback over longer periods of time.

These communities require a significant amount of management and maintenance however. Recruiting the right members will be an important issue for organisations to address. Samples cannot be representative as internet coverage is not universal.

4.5.9 Members' panels

Members' panels are an additional method of generating opinions, views and feedback from often large groups of people. Membership is dependent on a general relationship with an organisation, rather than a specific interest or concern i.e. Foundation Trust Member's Panels are comprised of representatives of the local community. The West Midlands SHA and four PCTs contacted for this research advised that they had established panels or networks of local people.

Contact and communication is generally limited to that which occurs between the organisation and panel members rather than between panel members themselves (the distinction between panels and online communities). Communication may be by electronic means i.e. email or traditional methods i.e. post or phone methods.

Case studies – members’ panels

Bradford & Airedale PCT has set up a panel of 500 local people. The PCT noted that recruitment had been ad-hoc and opportunistic, rather than systematic. The panel is being used to sound people out on a variety of issues. A two-page questionnaire is sent out each month and participants receive £50 if they respond to 11 out of 12 surveys a year. So far, the response rate is 70%. Participants have recently commented on the PCT’s commissioning strategy and strategic plans. Feedback is used to evidence business proposals put forward to the PCT Board.

West Kent PCT launched its Health Network in April 2008. The network currently has 500 members and is looking to expand to 1,000 in total. Monthly newsletters and surveys are sent out to panel members and members are encouraged to use the PCT’s website more for general and instantaneous feedback. Members are encouraged to actively involve themselves in the commissioning cycle through participation in events, focus groups and service redesign working parties.

The PCT acknowledges that its network membership is not presently representative of all geographic areas and more focused work is being completed to increase membership from harder to reach groups.

5 Using the data

This section considers some general points regarding the use of real-time data before going on to address some specific issues in relation to service improvement, commissioning and policy development.

5.1 General issues

5.1.1 Responsiveness

Respondents to the questionnaire and semi-structured interviews give a range of reasons for using real-time feedback, though these are grouped around similar themes. The three most mentioned reasons (8 -9 responses) are that: real-time feedback has greater credibility and validity among staff due to its immediacy, resulting in staff being more responsive; that it can help organisations be more responsive and address issues more quickly, thereby preventing problems from either escalating or being experienced by others; and that it can be used to drive quality and keep momentum going in service improvements.

The next most mentioned set of reasons (5-6 responses) are: that real-time feedback would demonstrate an organisation’s commitment and responsiveness

to service user satisfaction and public opinion; that commissioning organisations would find the results of real-time feedback useful in contract negotiations with providers; and that commissioning organisations would use real-time feedback to help plan services.

These reasons will be explored in greater detail later in this section.

5.1.2 Challenges

Respondents noted a number of factors that hinder the effective use of real-time feedback and feedback in general. These include a lack of clarity in terms of purpose, negative staff attitudes towards feedback, the lack of a common approach across providers and other partners, apathy and feedback fatigue among respondents and a lack of capacity and expertise to turn the feedback into actionable data. Two PCTs were concerned to manage patient expectations that real-time feedback would equate to real-time responses or actions.

Research tells us that the use of feedback is enhanced when feedback is actionable and when users know how to interpret and analyse the data. A degree of expertise and objectivity is required as individuals can be selective about interpreting results, selecting only those that meet with preconceived ideas and rejecting responses that don't. (Tasa et al 1996)

The evidence suggests that the most important factors influencing the effective use of feedback are: top level commitment, an organisational culture that supports learning, the appropriate resources and competencies and the existence of a formal strategy as to how feedback is to be used. (Tasa et al 1996)

5.1.3 Feedback

In 2005, Davies and Cleary reported that there was no published evidence that public reporting of survey and clinical data led to sustained improvement.

Evidence from this survey suggests that the focus is on collation and technology rather than outcome. In order to develop a more systematic approach to managing feedback by bringing together data from a variety of sources, a number of organisations reported that they were either considering developing a data warehouse type solution or had already taken steps to do so.

One PCT is developing a database that will capture all feedback, including the importing of comments from NHS Choices and Patient Opinion websites (though PALS contacts and complaints aren't yet part of the project). Another PCT is introducing a database for combining PALS and complaints information, though the PCT made the point that its capability to systematically process, collate and report on feedback was dependent on additional capacity and the acquisition of greater analytical skills to do something meaningful with the data. A third PCT intends to develop a data warehousing solution that would ultimately triangulate patient satisfaction data with clinical outcomes and patient reported outcome measures (PROMS).

A fourth PCT recorded its development of a central repository or 'evidence base' to collate feedback from a range of sources. A Patient Experience Analyst post has recently been appointed to lead this work. The intention for the system is that all staff can access a user-friendly search engine which will provide all the relevant feedback and information held on specific services or by condition etc by keyword. The same PCT is also looking to develop a consumer 'insight' function.

Case studies - feedback

The Veterans Health Administration (VHA), an organisation based in the US, delivers health care through 21 Veterans Integrated Service Networks (VISNs). These networks manage 153 medical centers, 731 community-based outpatient clinics, 135 nursing homes and 209 readjustment counselling centers. In 2007, VHA provided healthcare services to approximately 5.5 million patients.

The VHA try and gauge opinions from all of their patients while in hospital or just after, mainly by telephone, to ensure that feedback is given to all staff involved in their care. They have been very successful in gathering 'real time' feedback through this process and using it to improve quality of care. Their quarterly patient surveys have reported a 15% improvement in overall scores between 1995 and 1999. (Davies and Cleary 2005)

A key mechanism that supports the VHA effort is an IT system which the VHA has developed in-house over a long period of time, with significant investment. The amount is incalculable as it has been an incremental process, led by clinicians. Two reasons given for the VHA's ability to achieve consistency in practice across its 21 geographically diverse VISNs are; a lack of commissioner/provider split, and consistency in terms of organisational structures, systems and processes

This has implications for transferability to the NHS, given the diversity of structure and approach to survey feedback observed through this exercise.

5.1.4 Closing the feedback loop

Providing the results of surveys and feedback to staff, and providing staff with the opportunities to review this information, is as critical as providing it to patients and members of the public.

Respondents to the questionnaires provided few examples of how information was shared within the organisation, though this had not been asked for specifically. One West Midlands PCT described how it has a Patient and Public Involvement Trust Board sub-committee which retains an overview of all engagement activities and which monitors trends and emerging issues. This sub-committee receives information from its Local Involvement Network and patient groups affiliated to general practices. Information was not provided however on where data flows from the sub-committee and how it is shared more widely within the organisation.

One PCT distributes a bi-monthly newsletter to a range of stakeholders, including staff, which focuses on patient and public engagement. An acute trust not in the West Midlands is planning to develop an intranet page that will enable all staff to see the feedback it collects from patients. This approach was also proposed by another acute trust from out of the West Midlands area.

The Picker Institute has published a guide to sharing national survey results on its website. (Picker 2003) and this guide provides a couple of examples of good practice in dissemination. These include: directorate management teams in acute trusts discussing action plans with their teams; staff volunteers recruited to working groups which undertake specific improvement initiatives; use of posters displayed in public and staff areas; and articles in staff bulletins.

Huberman (1987, cited in Tasa, 1996), notes that an organisation's dissemination strategy is one of the most important aspects in effective use of research (or feedback). In Tasa's own study (1996), he notes that while senior managers are comfortable with numeric data and management-style reports, front-line staff are less comfortable with these methods and prefer graphical or audio-visual displays of patient feedback.

Case study – closing the feedback loop⁹

Lanarkshire Acute Hospitals NHS Trust carried out a survey of medical patients admitted to its three hospitals. The trust placed particular emphasis on sharing the results with their staff to drive quality improvements. Dissemination of the survey results began with a presentation to the Trust Board. As each site has a different culture and each general manager has a different approach, the results were subsequently broken down by site and circulated to each of the hospitals individually. Results were also discussed with the Local Health Council to help identify key issues arising from the survey. Arrangements were made for the results to be presented to various groups at each of the hospital sites. These meetings were open to all ward managers and heads of department.

Following dissemination, target areas for quality improvement were identified and nursing and medical and clinical outcome indicators were established. Specific projects on discharge planning and pain have been set up in response to patient feedback. The results have also fed into a patient information group and contract monitoring for facilities. Initiatives surrounding communication and customer care awareness have also benefited from the survey results. The Trust has set up programmes for ward managers and heads of department to give them the skills to help their staff deliver high quality care, particularly focusing on the patient's perspective. New projects are always related back to the survey results and the survey programme is seen as a long term quality improvement initiative.

⁹ Sharing survey results to drive quality improvement (reproduced from Picker's Good Practice database)

The 'You said, we did' aspect of engagement is often missed out by organisations, not because there hasn't been any change as a result of people's feedback but because not enough thought goes into this last but critical element.

A number of PCTs noted increasing apathy among people towards providing feedback with a couple suggesting this was caused by the fact that many people did not believe their feedback would have any effect. Six respondents overall suggested the use of real-time feedback could build trust by demonstrating an organisation was responsive to public views, with one PCT specifically noting the need to publicise the ways in which people had made a meaningful impact. Publicising the use of feedback, it suggests, helps build trust by showing people's views are taken seriously, and creates a dialogue with the community.

Publicising the use of feedback is currently managed in a number of ways by organisations, such as putting the results of surveys and any consequent actions taken on organisation's website or placing posters with the same information at strategic sites around buildings. One PCT, outside of the West Midlands, has also produced a newspaper recently, publicising in detail the changes it has made as a result of people's feedback. This has been distributed to all households in its area.

5.2 Focus for feedback activity

Our findings suggest that organisations have historically used feedback for service improvement and quality monitoring purposes, and while this is still often the case, there is increasing use of feedback by both providers and commissioners to inform service planning. Two PCTs noted the use of feedback to inform their Local Delivery Plan (LDP)¹⁰ in their questionnaire responses, while another recorded a use of patient feedback to inform the development of patient pathways. All PCTs responding to the questionnaire recorded using feedback to 'inform' commissioning decisions to some degree, though no detailed information was provided as to how it actually informed decision-making and whether any changes had come about as a result.

5.2.1 Service and quality improvement

Eight respondents (acute trusts and PCTs) noted that driving the quality agenda and service improvement were two of the main reasons for using real-time feedback. Details of how and where this had been achieved were not provided however.

Seven PCTs noted the use of real-time technologies to collect ongoing and regular feedback within their directly provided services i.e. District Nurse services, Podiatry clinics, Long-term Condition services, other community clinics etc. One PCT is also piloting real-time methods to capture feedback in a number of GP

¹⁰ Local Delivery Plans are annual declarations of commissioning priorities and investment strategies

surgeries, while a second PCT is hoping to have a couple of GP practices piloting these methods in the near future.

For feedback to be of maximum effectiveness in terms of service and quality improvement, organisations should be experienced in quality improvement processes and will need the capacity and skills to translate feedback into actions. (Davies and Cleary 2005) Tasa et al (1996) and Davies and Cleary (2005) note that patient satisfaction questionnaires and surveys do not in themselves indicate the course of action to take as they rarely provide recommendations; while they can pinpoint problems, they can't identify root causes. Turning feedback into action requires interpretive competency and effort.

This point was clearly made by one respondent - an acute trust from outside of the West Midlands. The Trust noted that real-time feedback is not 'a miracle cure' as feedback is only as good as the actions taken and while real-time surveys could deliver 'the what', they wouldn't deliver 'the why'.

Quantitative feedback from questionnaires may therefore be more useful at a strategic level to measure trends and to assist in planning where the organisation's focus should be i.e. improving cleanliness, staff attitude, communication etc. For front-line staff to use feedback, it must be translated into information about specific processes. (Tasa et al 1996)

Only qualitative data, such as patient stories, or initiatives such as Experience-Based Design (EBD) can provide rich enough information to deliver 'the why'. EBD and in some cases patient stories can also deliver 'the how'.

5.2.2 Strategic service planning and decision-making

Five PCTs specifically reported using real-time feedback to support service planning and decision-making. One PCT used the Picker Institute last year to conduct telephone surveys designed to solicit some 'trade off' questions for its annual LDP round (Local Delivery Plan). Other PCTs have also used public and patient opinion in similar ways – one PCT recorded the use of telephone polling to rate health services, while another noted gaining the public's views on how funds should be spent.

Another PCT, outside of the West Midlands, noted that members of its panel had recently provided feedback on the PCT's commissioning strategy and strategic plans. The same PCT also noted that patient and public feedback has been used as evidence to support business plans submitted to its Board. Recent developments influenced by public and patient opinion include increased GP opening hours, more community mental health workers and the launch of an Expert Patient Programme in Urdu.

One PCT reported its objective to directly involve a minimum of 5% of its total population (20,000) in planning and decision making by 2011 (it estimates that 1,500 people are so involved at present.)

Evidence suggests however that the public doesn't always have the same priorities and values as commissioners when it comes to making decisions on the funding of services. The public may value reducing mortality and an investment in life-saving interventions rather than interventions to reduce morbidity, such as smoking cessation services (Richardson et al 1992). The results from asking the public about priorities and allocation of resources, particularly in relation to public health type services, may therefore pose interesting dilemmas for commissioners. One PCT also noted that while real-time feedback is useful as part of a range of tools and techniques to gather feedback, it is limited as people may only give views at critical times when it may require that individual's experience of the whole patient pathway to inform commissioning decisions on the redesign of services.

5.2.3 Procurement

One PCT contacted has used members of the public on a panel awarding a new GP contract and intends to expand this model into other areas of procurement. Another PCT, from outside of the West Midlands area, also noted the use of members of the public in tendering and procurement activities.

5.2.4 Contract monitoring

Five PCTs noted the use of real-time feedback on quality and performance indicators to inform contract monitoring and contract negotiations with their providers.

One PCT reported a recent and noticeable shift in attitudes toward contract negotiations with providers. The PCT reported that these negotiations have moved away from being focused on activity and finance to being focused on quality and satisfaction indicators and have subsequently increased their impact. The PCT reports that changes to contracts have been implemented as result of this developing approach. It also noted that these types of discussions are easier with acute providers than community providers and independent contractors.

Another PCT, out of the West Midlands area, has introduced a system whereby its GPs can report incidents of poor care that come to their attention, whether the care has been delivered by acute providers or community providers.

A third PCT suggested that the gathering of real-time feedback from patients at different stages of their patient journey could assess whether they were receiving the service as required by the PCT in a service level agreement with the provider.

Case study – contract monitoring

Bradford & Airedale PCT has quality indicators built into all its Service Level Agreements (SLAs) and contracts with its main providers (two acute hospitals, a Mental Health Trust, the PCT's own provider arm, and Third Sector and voluntary organisations, with a private hospital to be included from next year.) The PCT

expects reports from patient feedback to be produced every quarter by their providers. These are then discussed at Contract Boards.

The PCT has developed templates and a toolkit for providers to use to monitor and measure engagement activities. Providers are expected to build up a portfolio of evidence that they are taking these issues seriously and are acting upon them. While the response from providers has largely been positive, the PCT acknowledges that not all are fully on board with this activity, as it requires a considerable shift in culture for some organisations.

5.2.5 Integrating real-time feedback into the commissioning cycle

The Department of Health recently commissioned work to develop a conceptual model which allows commissioners to understand how Patient and Public Engagement fit with commissioning. This model, known as the *E-cycle* (where 'e' stands for engagement) describes a consistent, yet flexible, model for engagement at each stage of the commissioning cycle (Gilbert 2008). Though this does not specify the use of 'real time' feedback, it may nonetheless, be an interesting and helpful way to understand where engagement and feedback is necessary and consequently what methods may be most appropriate at each stage. The model is currently being developed with the assistance of six PCTs, two of which are based in the West Midlands – Coventry and Dudley PCTs.

In order to embed PPE, the following elements need to be in place:

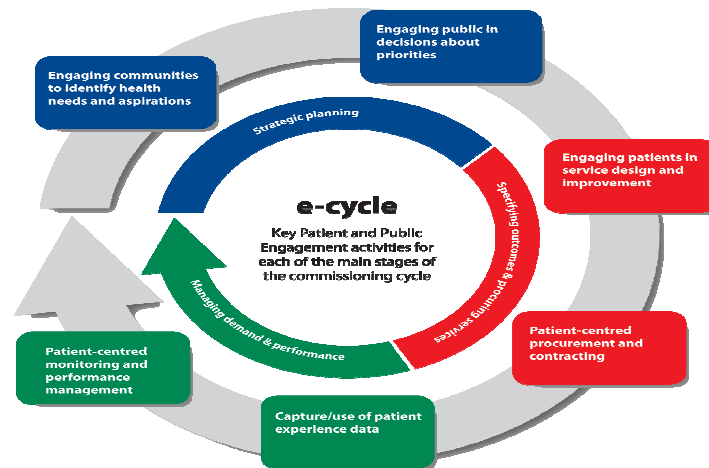
- Senior commitment and leadership to create a culture of engagement
- Strategy for engagement embedded into all areas of work
- Consistent approach to engagement across the organisation
- Robust mechanisms to capture patient and public feedback
- Solid reporting and monitoring systems as part of mainstream business
- Clear roles, responsibilities and accountabilities
- Adequate resources and practical support
- Learning and development for staff and non-staff
- Underpinned by principles of partnership working
- Equalities and diversity as a cross-cutting theme.

However, the particular approach for PPE activities should depend on the purpose of engagement, which in turn will depend on the stage of commissioning. Different approaches to engagement may be necessary for each of the three main stages of the commissioning cycle. At each of these three stages, there are two key PPE purposes:

- Strategic planning:
 - Engaging communities to identify health needs and aspirations
 - Engaging public in decisions about priorities
- Specifying outcomes and procuring services:
 - Engaging patients in service design and improvement
 - Patient-centred procurement and contracting
- Managing demand and performance management:
 - Capture and use of patient experience data
 - Patient-centred monitoring and performance management.

An initial draft version of the E-cycle and suggested points of engagement are shown below in figure 1.

Figure 1: E-cycle



Source: David Gilbert, InHealth Associates - email communication, October 2008

At each of the different stages of the cycle, there are different purposes to engagement, different stakeholders involved and different approaches required:

- Each stage of commissioning may require engagement with varying stakeholders. For example, identifying health aspirations with communities is different to public engagement with citizens (as taxpayers) in prioritisation decisions, where accountability is key. Patient engagement in service planning and improvement work brings in another set of stakeholders
- Sometimes there may be differences in the levels at which PPE is undertaken. Engagement in identifying health aspirations and decisions on priorities are often corporate-led activities. Patient engagement is often at service level or across a particular pathway
- In terms of who leads the process, there may be a multi-agency approach (identifying health aspirations and prioritisation) or PPE may be led by commissioners (planning and procuring services). For performance management and monitoring, commissioners and providers need to be clear about their roles in terms of gathering and using data about the patient experience
- Though many methods of PPE can be adapted for multiple purposes, some may be more useful at particular stages i.e. community development approaches to identify health aspirations or deliberative events for priority setting.

5.2.6 Delivering key policy objectives

Only a couple of respondents specifically mentioned the use of real-time feedback to deliver key policy objectives. One acute trust noted the potential influence there may be on Patient Choice if results of their real-time surveys are published on its website. A PCT also referred to real-time feedback as enhancing public choice. Two PCTs thought that real-time feedback would support World Class Commissioning competencies, with one of those specifically mentioning Competency 3 – which relates to how local people are involved in decision making.

One PCT also raised Section 242 as an additional organisational duty under the newly strengthened directive to provide responses to people who have provided feedback.

5.2.7 Current level of investment and resources

It is apparent from our survey that each organisation has its own approach when it comes to resourcing the gathering of feedback and translating this into action, in terms of both staff resources and investment in equipment, systems, training etc. In addition, the responsibility and accountability for this sits within different departments from organisation to organisation, so that there is no standard model for how this can be managed and resourced.

The majority of organisations did not provide detailed information about staff complements or budgets, with many stating that funding for these activities was drawn from a number of sources and could not therefore be identified separately or disaggregated.

It is possible however to provide some costs for specific activities and to provide a range of responses in terms of which departments or individuals play a main role, though comparisons between organisations are impossible, as the size and profile of each will differ, resulting inevitably in differing needs and priorities for engagement and involvement work.

One PCT reported costs of £25K per annum for the use of Patient Experience Trackers (PET). One PCT provided indicative costs of £25K for a mystery shopper activity, £30K for a medium size survey of its provider services and £8k for a small local survey on users of a new health centre. A PCT, outside of the West Midlands recorded spending £8k on a newspaper to encourage feedback and to promote the actions it had taken as a result of previous feedback from patients and the public. This was distributed to each household in its area. An acute trust noted spending £7K on a recent patient census.

Two PCTs noted their investment in purchasing hand-held devices but did not provide costs. A third PCT discussed its investment in 48 touch screen kiosks and training for staff to carry out patient story interviews but again did not provide costs. Another PCT noted it was investing additionally to: develop a social marketing project; extend its Citizen's Panel; and to create a bespoke PPI

database but did not provide any figures. One PCT also noted it had recruited an analyst to triangulate feedback data from different sources into an internal web-based system.

An acute trust outside of the West Midlands reported its investment in a part-time Information Management and Technology post to support its activities. Another acute trust outside of the West Midlands reported a budget of £20K for a project team to introduce real-time technology from 2009.

Responsibility within PCTs generally lies with Communication and Engagement Teams or Patient and Public Involvement teams. Where staff complement has been provided, two PCTs noted a team size of four. One PCT, outside of the West Midlands, recorded a stakeholder engagement team of 8.5 WTEs, which did not take into account PALS staff or staff dealing with complaints. Another PCT, outside of the West Midlands, has a Patient Outcome Team of two Whole Time Equivalents (WTEs) which sits within its commissioning function - the PCT noted it was also looking to increase capacity within the team. A third PCT, outside of the West Midlands, has a Civic Engagement Team of 16 people, though this includes customer services, communications, user research and stakeholder engagement.

One acute trust respondent has a PPI team employing four staff of varying grades plus administrative support which is responsible for these activities. Responsibility for getting a real time project off the ground in another acute trust lay initially with the Head of Clinical Governance but will be transferred to its PPI department in due course. In a third acute trust, the Head of Patient Partnership has overall responsibility for patient engagement and experience (PEE) but uses a network of part-time PEE leads in each of its nine clinical groups to undertake these activities on the ground.

5.2.8 Effectively using data

The NHS has become much better at gathering feedback from service users and utilising a range of different technologies and approaches to do so. But a problem remains in effectively using that feedback to develop and improve services. Studies consistently demonstrate that the effectiveness of using patient survey data is limited (Wensing and Elwyn 2003), that patients' views are not systematically incorporated into decision-making and that a substantial democratic deficit remains (Fudge, 2008).

While discussing implementation and taking action (effective use of findings) was not part of this commission, this is a significant theme common to findings in the literature and in our study, and therefore needs addressing. Section 6 discusses a series of steps that together, can provide the basis for a strategic approach to implementing survey feedback, whether real-time or otherwise.

6 Implementation

A key theme emerging from this study, consistent with the literature, is that simply giving organisations, teams or individual clinicians the results of patient feedback is not enough to improve their performance. This is consistent with the substantial body of research which shows that survey feedback is often not used systematically by organisations to trigger, inform or guide quality improvement activities (Vingerhoets, 2001; Wensing, 2003).

There are two factors that are critical to the effective use of patient feedback. First, data should be gathered using *robust methods*, from a cross-section of different groups, in ways that are acceptable to patients and are appropriate to their particular circumstances. Second, those *data should be fed back to staff and used by them* to improve the patient experience.

6.1 Robust approaches for designing and using survey feedback

The evidence from the literature and this study suggest that together, the following key points constitute a robust approach to designing and using survey feedback methods including real time methods:

6.1.1 Clarity of purpose and timing

An organisation should ask itself what it is trying to achieve by using real-time feedback and whether it can provide the right sort of evaluation. While real-time feedback is useful as part of a range of tools and techniques to gather feedback, it is unlikely to be a cure all.

The timing of data collection is a critical aspect to ensure organisations use feedback effectively. For service and quality improvements, the ‘fresher’ the information, the more effective it can be. For long term strategic purposes, the timing of data collection is not necessarily as important as ensuring it is collected on an ongoing basis from a representative sample of the population and is used systematically and according to a clearly defined strategy.

6.1.2 Use of ‘real time’ methods

The gathering of real-time feedback can bring clear advantages to an organisation. However it should be clear from the outset where real time fits into its overall strategy for gathering and using feedback.

Organisations will also need to take into account the needs of all potential users when considering which methodologies it may wish to introduce.

While patient feedback from surveys and technological methods identifies broad areas or issues where improvement is needed (the what), rarely does it pinpoint specific problems or provide answers as to how these might be resolved (the why or how). Often further information needs to be gathered to find out the cause of

the problem and this may require additional resources, time and commitment. In these cases, qualitative approaches have clear benefits in finding out answers to 'why' questions; the use of patient stories or volunteer interviewers can be effective.

6.1.3 Survey design and methods

Often feedback survey design is determined by managers or researchers, rather than by patients. Organisations should involve patients and the public in determining what is important to them and therefore what should be measured, bearing in mind that measuring satisfaction alone will not necessarily provide the sort of information an organisation can act upon to effect change.

In order to maximise response rates, increase representation of the population as a whole and avoid sampling bias as far as possible, organisations will need to employ a range of methods to gather feedback.

6.1.4 Engagement and methods

Given the relationship between feedback methods and the engagement of people, providing a range of methods and opportunities to solicit feedback is recognised as an important element for an engagement or communications strategy by organisations; it is universally acknowledged that no one method will reach every section within the community and no one method is suitable or preferred by everyone.

There is considerable evidence that response rates vary among different groups and certain groups are significantly under-represented such as BME communities and people with disabilities. Organisations need to be mindful of this in determining approaches and methodologies.

A key component of patient enthusiasm for feedback is the power they are given to improve things for other patients. Organisations can capitalise on this, providing they are committed to making change happen as a result.

6.1.5 Technical expertise

Questions asked in surveys are often the wrong ones and do not collect the data required; this is often down to poor skills and a lack of knowledge to ask the right evaluation questions. Clarity over what is being measured or evaluated will determine whether the right questions are being asked. For this to be effective, skill and expertise is required to formulate the right questions, analyse data and to turn feedback into actionable information.

Questions should be worked up from patient needs into key priorities and these used to determine the questions and measurements required.

6.1.6 Organisation and administration

Organisations are spending a considerable amount of time and resources on gathering data. While some organisations are using this information to good

effect, this investment nevertheless risks generating a poor return if they do not approach this in a systematic way.

To both ensure effective use of feedback and action taken, organisations need to ensure that they develop a formal strategy and organisational processes for co-ordinating data collection, collation, analysis and dissemination. For services that are provided across organisational boundaries, this should include engaging with Local Authorities to develop a joint approach for both providers and commissioners.

Where the responsibility lies for gathering feedback, its analysis, reporting and taking action needs to be clear and understood by all within the organisation.

6.1.7 Feedback loops

A feedback loop to staff, patients and service users is a critical element of the process. Without this, organisations risk losing public trust and ongoing engagement as results will not be implemented.

Staff particularly appreciate receiving feedback in the patient or users own words as this makes the comments more 'real' to them. By effecting immediate changes, based on real-time data, it should also be possible for organisations to better understand what actions have had what specific effect.

Feedback is more effective when the findings are disseminated in tandem with educational programmes or quality improvement guidance.

6.2 Factors that can hamper implementation of patient feedback

Davies and Cleary (2005) reported some broad factors that can hamper the implementation of patient feedback relating to data, professional practice and organisational processes. These are shown in Box 12 below.

While the collection of real-time patient feedback overcomes some of the data-related barriers such as timeliness, it does not address those relating to organisational culture, resources, professional attitudes or practice.

It is possible that an organisation could invest heavily in methods to gather real-time feedback, but find that these do not deliver better outcomes as expected because other barriers are still in place. This suggests that real time systems should only be implemented alongside a broader programme to develop a quality improvement infrastructure and resources at all levels of an organisation.

Box 12: Factors that can hamper the implementation of patient feedback

Organisational barriers

- Lack of supporting values
- Competing priorities
- Lack of quality improvement infrastructure

Professional barriers

- Clinical scepticism
- Defensiveness and resistance to change
- Lack of staff selection for skills (i.e. recruitment against a skill set which is too narrow)

Data related barriers

- Lack of expertise
- Lack of timely feedback
- Lack of specificity and discrimination
- Uncertainty over effective interventions and rate of change

Source: Davies and Cleary, 2005

In Section 6.3 below, we discuss a series of steps that together, can provide the basis for a strategic approach to implementing survey feedback. These include:

- Developing a patient centred approach
- Creating a structured process for quality improvement
- Building a system of leadership for improvement
- Adopting organisational development principles
- Feedback to, and involvement of, staff
- Working with human responses to change

6.3 Systematic framework for implementing feedback

6.3.1 Developing a patient-centred approach

As stated at the beginning of this report, patient choice and satisfaction are central tenets of government policy, and we can see how this policy is influencing the way in which services are designed and delivered in health and social care (Klein and Millar, 1995; Davidson & Vick, 2002; Hughes, 2004; Spandler, 2004).

The strengthened statutory duty – Section 242 – which requires NHS organisations not only to gather patient views, but also to demonstrate how these have influenced decisions, will go some way to creating a more patient-centred culture. But organisations also need to build the right internal systems and processes to encourage greater responsiveness to patients and the public. The NHS Centre for Involvement (NCI) organisational development team

identifies six factors which are most likely to promote a successful and sustainable approach to patient involvement:¹¹

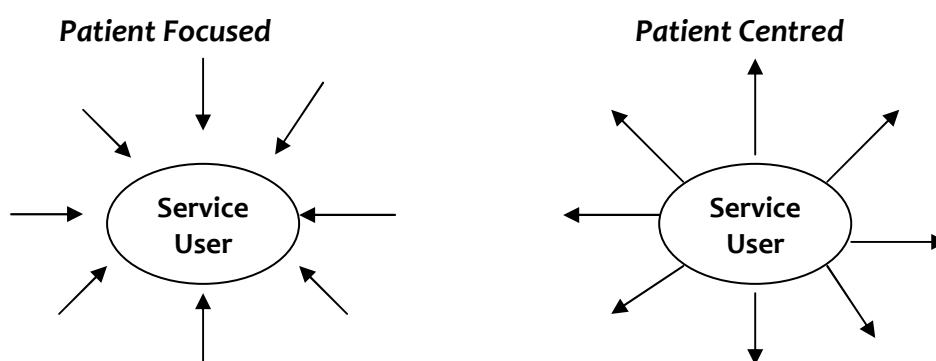
- A coherent involvement strategy and clear action plans
- Senior commitment and leadership
- Proper resourcing and support
- Clear roles and responsibilities
- A commitment to partnership working, equalities and diversity
- Effective mechanisms for evaluation and sharing the learning.

Research by the NCI suggests that, above all, it is a commitment to involvement among senior executives that influences how organisations value and use patient feedback. A clear message emerges about the importance of leading by example. If the Board does not show how it takes patient views into account in its decisions, then it is unrealistic to expect front-line staff to do this in their own work.

While this strengthened duty is positive, and will take a step in the right direction of what Davies and Clearly (2005) refer to as ‘supporting values’ there is a danger that it becomes one more target to meet or box to tick. Instead, what is required is a more radical culture change in how organisations view and involve service users and patients.

Traditional approaches have tended to be *patient focused* as opposed to *patient centred*. There is a difference in the meaning of the terms ‘patient focused’ and ‘patient centred’. This is simply illustrated below:

Figure 2: The difference between patient focussed and person centred



Patient focused activities are those that focus on the patient but where the service maintains the power, as previously, to decide ‘for’ the patient. The most common example of this is consulting patients about what they want and then taking action. Using this example, a patient or person centred approach would be to work alongside users and support them to articulate their experience, and involve them in making the change.

¹¹ See www.nhscentreforinvolvement.nhs.uk, specifically the website pages relating to the organisational development projects in partnership with the Centre.

Experienced based design (Bate and Roberts, 2007) is one of the more radical and innovative approaches currently being developed in healthcare. This approach is about “being mindful of experience and the need to build that mindfulness into what we do ...as quality improvement specialists” (ibid: 58). It draws on the design sciences and the design professions, such as architecture, computer, product and graphic design, for its ideas.

With a design framework, the focus for change shifts from change to improvement and from process to outcomes, ultimately to lead to a better experience for service users/patients.

It is claimed that central to any good design process – whether for trains, computer equipment or healthcare systems - there are three common components. These are shown in figure 3 below:

Figure 3: The components of good design

Performance	+	Engineering	+	The Aesthetics of Experience
How well it does the job /is fit for purpose		How safe, well engineered and reliable it is		How the whole interaction with the product/service ‘feels’/ is experienced
(Functionality)		(Safety)		(Usability)

Source: Berkun, 2004

Healthcare has always been deeply involved with the first two aspects of design - ‘performance’ in terms of the use of evidence based practice, pathways and process design, and ‘engineering’ in terms of clinical governance and standards and safeguards for patients. However, it has never explicitly engaged with *designing human experiences*, as distinct from designing processes. In addition, the traditional mindset continues to focus upon preference and choice¹², listening, understanding and responding, supporting, consultation and complaints, where influence rather than experience is the focus.

Bate and Roberts state that the key challenge to staff taking a patient centred approach would be to help users/patients involved, “to design and develop a process that will lead to services being better in the user’s terms,”(2007:46).

To do so, they cite four key lessons from their research that need to be incorporated:

¹² Which is now further emphasized by the consumerist approach to public service delivery

- Such an approach requires new value commitments and orientations where the focus is on co-production between the organisation and staff (internal) and the user and stakeholders (external);
- Good service design is a core goal and simultaneously needs to address all three design components – to be functional, well engineered and a good experience for service users;
- Methods for data collection, analysis and organisational change that are more visual, tactile, exploratory, expressive and creative are fundamental to creativity and innovation breakthroughs; and
- The bringing of staff and patients together on a regular basis to share stories, listen to each other and work on creating solutions together, provides the impetus for mobilizing change beyond commitment and engagement.

“Mobilizing images and mobilizing narratives...help those involved construct a shared identity...and the deep sense of purpose...” (Bate and Roberts, 2007:63)

6.3.2 Creating a structured process for quality improvement

Evidence from the organisational change literature (Cummings and Worley, 2001) suggests that the first and most important task in implementing change is to establish an infrastructure for the change process. Without an infrastructure, a project is unlikely to succeed or develop with any coherence.

For survey feedback, this is also articulated in the healthcare literature where “a structured process for addressing problems and obtaining resources was critical in marshalling energy to tackle issues raised by surveys” (Davies and Cleary, 2005:431) as well as a drive to motivate staff to produce changes (Rogut and Hudson, 1995).

Tasa and colleagues (1996) suggest that the most important factors influencing the effective use of feedback are top level commitment, an organisational culture that supports learning, the appropriate resources and competencies, and the existence of a formal strategy on how feedback is to be used.

Much of this is also reflected in Øvretviet’s review of the literature on leadership in healthcare quality and safety (2005). However, in contrast to Tasa et al (1996), Øvretviet found that there was only some evidence of the importance of top level commitment from CEOs, Boards and senior managers (adding organisational credibility and authority to medical leadership) to service improvement, and examples provided were mostly based on consultancy or personal experience rather than empirical research. (Crosby, 1979; Deming, 1986; Gaucher & Coffey, 1990)

Other factors found to be important to successful improvement included choice of improvement undertaken, adaptation to local setting, continual review and revision.

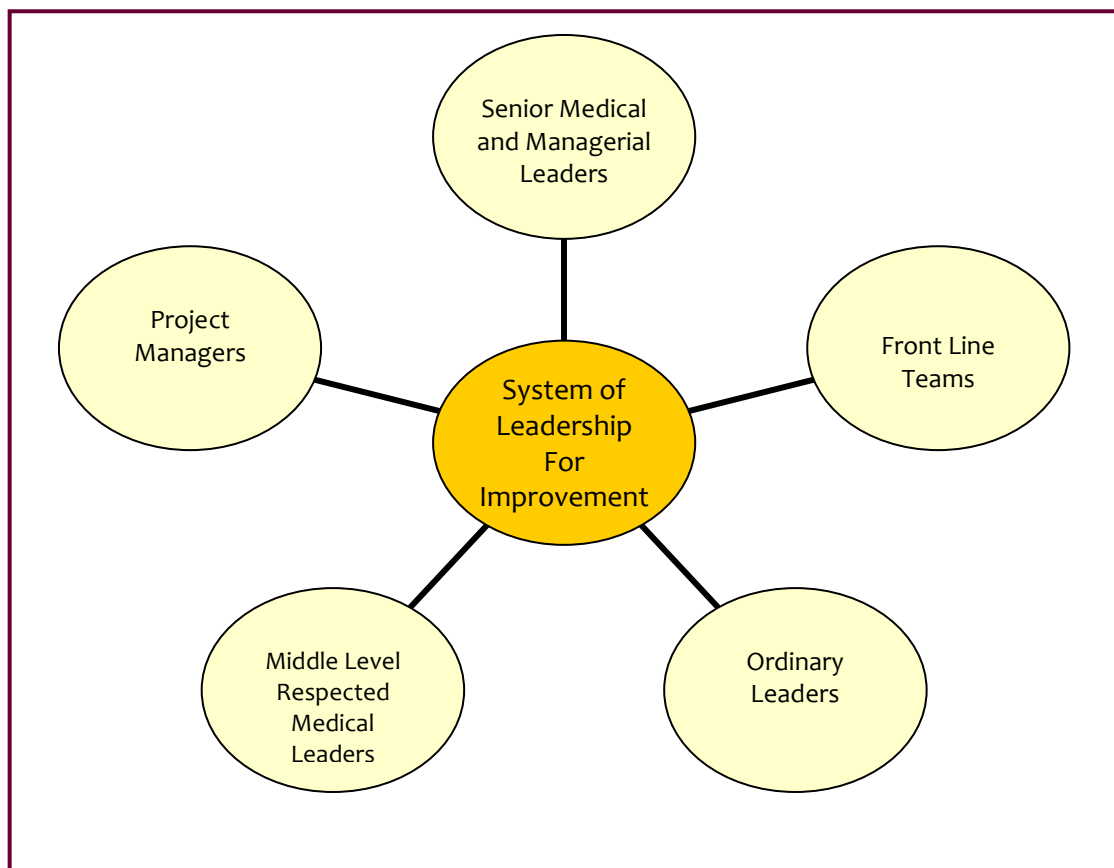
6.3.3 Building a system of leadership for improvement

Given the multiple factors Øvretviet (2005) found to be important to quality and safety improvement, the structured process he suggests, is building a *system of leadership improvement (SLI)* which:

- Consists of all the formal and informal leaders, teams and groups which support improvement as part of their everyday work;
- Identifies and stimulates a variety of champions to collectively agree priorities and methods for improvement, and ensures this is led by those champions in a consistent way and in a common direction;
- Values and harnesses the energy of ‘ordinary’ leaders¹³; and
- Institutionalises improvement and reduces dependence on senior managerial leaders, who are often transitory.

Empirical and less well researched evidence all points to the crucial involvement of five particular roles (not people) that together, form the core of an SLI. This is shown in figure 4 below:

Figure 4: A system of leadership for Improvement



Source: Adapted from Øvretviet, 2005

¹³ People who have been employed some time and “have detailed knowledge of how work is organised – who does what and how – and know who to contact to get things done and who are known widely in the organisation....These people can also block or slow down change, but if inspired and allowed to contribute have a significant role to play” (Øvretviet, 2005: 422-3).

The most common finding associated with successful or failed improvement concerned the ‘engagement’ of senior clinicians, in particular doctors: “Involving doctors stands out from the empirical research as the most important [and] necessary (but not sufficient) factor for improvement success.” (Øvretviet, 2005:419).

Øvretviet suggests four elements that need to be built into medical engagement:

- Senior and middle clinical leaders have a role to play;
- Influencing ‘opinion leaders’ is a successful way of gaining involvement;
- Managers need to identify clinical leaders and the communication networks to which they belong, and actively influence them and gain their support; and
- Providing time, resources, incentives, data and evidence of results is also necessary for doctors to be involved.

6.3.4 Adopting organisational development principles

The organisational development literature (Cummings and Worley, 2001; Block, 2000; Neumann, 2008) suggests a number of factors which are essential when creating an infrastructure for change. Neumann (2007) offers some organisational development and change *design rules*, which are useful to consider when thinking about the constitution of the SLI:

Box 13: Design rules for organisational change

1. Those leading change need to come together in the form of a working group to plan and implement the change
2. Working groups need to include authorised stakeholders from across the whole system:
 - Those in a senior strategic role to bring in the wider picture and external considerations
 - Those who have the authority for decision making (clinical and managerial) and the use and allocation of resources
 - Staff who will be involved in implementing the change themselves
 - Service users who provided feedback.
3. Adapt the membership to meet the implementation needs as discovered and required (requisite variety)
4. Never forge ahead with changes without explicitly negotiating and planning what needs to happen with appropriate representatives of the service where feedback is sought
5. Use appropriate participation and involvement throughout, enhancing the staff’s ability to do the same on their own
6. Design each stage for trust formation and development around current and unresolved issues
7. Legitimise people’s difficulties with change and work with what emerges
8. Design developmental processes for stakeholders to work together on their disagreements, especially in cross-boundary settings.

Source: Adapted from Neumann, 2008

6.3.5 Feedback to, and involvement of, staff

Providing the results of surveys and feedback to staff, and providing staff with the opportunities to use this information, is as critical as providing it to patients and members of the public.

Likert, Mann and colleagues discovered, as far back as 1947 that for change to occur two crucial things had to happen:

- Survey information had to be reported to service managers/supervisors; and
- The results needed to be discussed and service improvements planned together with the staff that provide the service.

Evidence from research (Mann, 1957; Bennis et al, 1961) showed that when managers discussed results with subordinates and planned with them what to do to bring improvements about, substantial favourable changes occurred.

Baumgartel (1959) also discovered that intensive, group discussions for utilising the results of surveys can be an effective tool for introducing positive change in a business organisation, and is more effective than traditional training courses, as it:

- Provides opportunities to deal with the system of human relationships as a whole (manager– subordinate can work on change together); and
- It deals with each manager, supervisor and employee in the context of their own job, job challenges and work relationships.

While these findings on use of survey feedback methods are dated, they nevertheless still have relevance for today given the research findings that data is being collected but not used or used effectively (Wensing and Elwyn, 2003; Fudge, 2008; Vingerhoets, 2001; Wensing, 2003).

6.3.6 Working with human responses to change

In almost any book on change you will find a section on *resistance* and a series of actions or steps that can be taken to overcome that resistance. In the public sector, including healthcare, there is a dominant view that people's response to change has to be "can do"; alternative responses are seen to be a sign of lack of competence and people are often labelled as laggards.

However, there is considerable evidence to suggest that people do not resist change per sé, and instead have responses to the specific effects of change (Dent and Goldberg, 1999; Kubler Ross, 1997; Marris, 1993; Broussine and Vince, 1996).

People's responses to change are varied, and neither simple nor predictable. Some people embrace change as challenges, opportunities or something new and exciting. Others may experience a loss of status or feel isolated after close working colleagues move as a result of changes in structure and location. Hoyle (2004) states that as people engage with change they will be "taking risks, generating uncertainty and facing the possibility of failure which can evoke anxiety in themselves and others around them."

Some common causes of difficult responses to change include a lack of knowledge and understanding of the changes that are planned; difficulty as a result of the way the change was introduced; a fear of the unknown; defensiveness; existing customs conflict with the planned change; a lack of trust and poor working relationships with management; fixed views and ways of seeing the world that make it difficult for people to see the benefits of a new way of working; and feelings of insecurity and anxiety.

Whatever the cause, the literature on change suggests that if the *people* issues are not identified and worked with effectively, some of the following problems may arise (Buchanan, 2001): strong emotions, such as fear, anger, hopelessness and frustration; people become defensive; constant complaining, questioning and scepticism; increase in absenteeism, sickness and people leaving the organisation; a fall in morale and job satisfaction; people don't match words with deeds; conflict can become more difficult to resolve.

Articulating her *design rules* for organisational change, Neumann (2007) clearly states that people's responses - including difficulties - need to be legitimized and worked through. Dent and Goldberg (1999) suggest that making effective changes requires specific targeted action, for example loss of status requires strategies for dealing with loss of status; loss of jobs requires strategies for helping people who are going to be made redundant. "Labeling these difficult problems as resistance to change only impedes the change effort" (ibid: 40).

What is clear from the research on managing change, is that ignoring, denying or avoiding addressing people's responses to change will negatively impact on the change effort, because the feelings and attitudes of staff are not worked through.

In the NHS, a term commonly found is 'winning hearts and minds', suggesting that a strategy for changing people's mindsets is required. The organisational development literature (Marris 1993, Lurigio and Skogan 1994, Bridges 2003 and Hoyle 2004) suggests that change requires making a transition from one situation to another, and that loss needs to be acknowledged and worked with before people can move on.

Positive psychology, for example Seligman's work (1972), is influencing thinking about how to work with people's responses to change. This focuses on positive and energy giving approaches rather than negative, energy depleting approaches. Others have adapted the principles of positive psychology to working with organisational members who find change difficult. Cavanagh and Grant (2005) found that if you identify the factors that are positive about staying in the same situations (underlying needs), you can then work on how to satisfy these in new and changed situations.

Whatever, approaches are taken, knowing what people are feeling and thinking will help those leading change to shape the change process, and legitimise people's responses to change.

7 Implications for commissioning and strategic policy implementation

The purpose of this study was to look at best practice in relation to the methodologies and techniques for gathering real-time patient/user feedback and how this feedback is successfully acted upon by organisations across both NHS and non-NHS settings.

Our findings suggest that organisations have historically used feedback for service improvement and quality monitoring purposes, and while this is still the case, there is increasing use of feedback by both providers and commissioners to inform strategic service planning. All PCTs responding to the questionnaire recorded using feedback to 'inform' commissioning decisions to some degree, though no detailed information was provided as to how the data actually informed decision-making and whether any changes had come about as a result.

Nevertheless this is a source of data and activity that has the potential for driving a commissioning agenda. For NHS West Midlands and PCTs, the key question is how do they want real-time patient feedback to be used to drive commissioning decisions locally?

Given the paucity of research in relation to the use of real-time patient feedback for commissioning, we cannot provide evidence or conclusions about what works. We can however discuss the implications for commissioning that have emerged from this study and the conversations that have ensued as a result, which indicate some of the thinking and ideas currently being worked on, in the healthcare field.

7.1 Accountability

Organisations need to hold themselves to account for acting on the feedback that they gather. The Board, as the accountable body within a Trust or PCT, should be the accountable body for acting on feedback, with the Chief Executive and Medical Director being ultimately responsible for implementation. (See Appendix C for accountability structure).

Just as organisations monitor and report their use of finances, so they should monitor and report on engagement and involvement with, and feedback from, service users and patients. This might include the Board:

- Assuring itself that the organisation is properly equipped for PPI
- Requiring, reviewing and responding to reports from teams/wards/services about how they are responding to feedback from their users
- Showing leadership by example e.g. demonstrating to the rest of the organisation how it takes feedback into account in its decisions.

7.2 Implications for SHAs

7.2.1 Providing frameworks for action and change

Implementation of real-time patient feedback requires a strategic and systematic approach if it is to be useful and successful. The steps discussed in section 6.1 of this report act as a good practice guide for designing, gathering, analysing and disseminating feedback, in order to improve the quality of care.

Section 6.3 suggests the elements required for a strategic framework for implementation. This resource will support providers specifically but can also enable PCT commissioners to have more 'informed' commissioning discussions.

The points set out here in Section 7 will hopefully stimulate a discussion and debate about what steps SHAs and PCTs need to take. Responses to our questionnaire argued strongly against an imposed set of outputs. Given their strategic role, at the very least SHAs can establish a process for whole health economies and PCTs and set out a broad framework, based on outcomes that can then be worked with at a local level.

7.2.2 Benchmarking and comparison at whole health economy levels

Although not tested, one suggestion for using real-time patient feedback is for SHAs to establish priority areas across a whole health economy, for example diabetes, radiology or trauma services. Feedback could then be gathered as part of a rolling programme in every Provider Trust, and this data collated to benchmark and compare service outcomes.

The benefit of this approach would be to raise standards across a whole region. However, as shown in this report, there is a danger in relying on data that is collected at one point in time, as it might distort the true picture of experience across a more extended period of time.

7.2.3 Investment for capacity

Our study showed that each organisation has its own approach when it comes to resourcing the gathering of feedback and translating this into action, in terms of both staff resources and investment in equipment, systems, training etc. In addition, the responsibility and accountability for this sits within different departments from organisation to organisation, so that there is no standard model for how this can be managed and resourced. What is clear from the questionnaire however, is that PCTs state that increased investment for capacity to collect, collate and analyse data and follow up in implementation is required.

7.2.4 Creating indicators for assessing user experience

The Audit Commission suggests that expectations have been influenced by substantial leaps taking place in citizens' daily lives over the last 15 years as commercial consumers and that there is a real concern that UK public services are not ready for this quantum leap (Audit Commission, 2001).

If the gulf between what we can buy as customers and what we get as public service users is to be bridged, then commissioning must take a strategic role in crafting out indicators for user experience that could be used in commissioning discussions.

The literature clearly provides some guidance for this. For example Hughes (2004), Perri 6 (2003) and Klein and Millar (1995) discuss consumer choice goals, which might act as potential indicators for commissioning against which evidence is assessed:

- *Outcomes* (choice itself has positive benefits for consumers)
- *Acceptability* (it may be politically important for government to be seen to offer consumers choice)
- *Satisfaction* (consumer satisfaction is raised by consumers having choices, typically about *content* and *level* but also of *provider*)
- *User convenience* (in practice services will be organised around this recognition)
- *Responsiveness* (promoting contestability, as a discipline upon providers to offer service content that consumers actually want, in respect both of quality of current service models and innovation in content)
- *Exercise of choice* (How is the service provided? Does it empower and respect the individual service user? Does the service setting appear to be clean, well-organised, friendly and trustworthy?)

However, Bate's and Roberts (2007) plea needs to be heeded; that whatever indicators are developed, the design and process will lead to services being better in the user's terms.

7.3 Implications for Commissioners

7.3.1 Real-time or right-time feedback

Getting feedback at the right time - not necessarily in real time – seems to be a key issue commissioners have to grapple with.

For long term strategic purposes, the timing of data collection is not necessarily as important as ensuring data is collected on an ongoing basis from a representative sample of the population and that this is used systematically and according to a clearly defined strategy, which includes benchmarking.

However, there needs to be a trade off between these more robust and standardised processes for data collection and analysis, and processes that enable commissioners to respond quickly to local population needs, individual organisational priorities and user experience, which demonstrates that it is making a difference in the short term.

7.3.2 Managing public expectations

Our study found that there was some concern about managing public expectations, particularly in relation to asking for people's views on "matters that cannot be changed or are not up for discussion" or raising expectations that real time patient feedback would mean real-time action or real-time acknowledgement of change, when this could not be provided.

Culture change, in terms of the way in which services view and work with service users, e.g. experience-based design (Bate and Roberts, 2007), might mean there will never be a situation where matters cannot be changed or are not up for discussion. Instead, there needs to be a process of *robust dialogue*, which works with the realities and lived experiences of service users, staff and government targets.

7.3.3 Prioritisation and decision-making

As discussed previously decisions are often made, and methods determined, by staff rather than by patients or the public. Evidence suggests that the public doesn't always have the same priorities and values as commissioners when it comes to making decisions on the funding of services. The public may value reducing mortality and an investment in life-saving interventions rather than interventions to reduce morbidity, such as smoking cessation services (Richardson et al 1992). The results from asking the public about priorities and allocation of resources, particularly in relation to public health type services, may therefore pose a dilemma for commissioners.

Despite this dilemma, commissioners should involve patients and the public in determining what is important to them, including priorities based on their experience of using services. Public education on healthcare matters before soliciting views and opinions is one way of engaging local citizens and patients in a meaningful dialogue; use of member panels might facilitate such a dialogue.

However, commissioners also need to be alert to seeking the views of people who often don't access services such as those from black and minority ethnic communities, people with disabilities, elderly people and young people. Undertaking an Equality Impact Assessment as part of the process might help ensure that people who are generally excluded do not remain at the margins of good healthcare provision.

7.3.4 Bringing patient experience into contracting

Contracting meetings with providers, until recently, have typically involved setting a base line for expected levels of activity (using historical data) at the beginning of a financial year. Actual activity levels are then regularly monitored against expectations over time. The focus of discussions traditionally has been on activity levels and finance, with people in technical roles such finance or IT generally in attendance.

More recently, the quality of care has started to enter these discussions, with the development of quality indicators and an expectation that providers will actively engage with their patients and service users. The case study of Bradford and Airedale (see section 5.2.4) is a good example of this.

Patient experience and outcomes – whether gathered in real-time or otherwise – are fundamental if both providers and commissioners are to “construct a shared... and deep sense of purpose...” (Bate and Roberts, 2007:63).

7.3.5 Using real time feedback to drive commissioning decisions

PCT responses to our questionnaire and interviews reported a range of uses of real-time patient feedback to support strategic service planning and decision making, procurement and contract monitoring. These are discussed in detail in section 5.2 above.

In many cases, the returned questionnaire did not provide any detail on how questions were determined and how these related to user needs and experiences - a number of instances of use appeared to be general consultation exercises. In some cases however, PCTs are actively using feedback to inform commissioning decisions, for example to increase GP opening hours, increase community mental health workers and to launch an Expert Patient Programme in Urdu.

One of the key issues that emerged from discussions was the need to work with commissioners to understand how information can be used to trigger decision making as part of the commissioning cycle.

The E-cycle (see section 5.2.5 above) – commissioned by the DH and developed by David Gilbert – is currently designed to look at how and when patient and public engagement fits into the commissioning cycle. This seems a useful tool for considering the place of real-time feedback. The E-cycle could be promoted to provide a measure of consistency of approach across organisations.

7.3.6 Quality accounts and CQUIN

This year, the DH is introducing *quality accounts* to be scrutinised alongside financial accounts. These are formal publications produced by providers which will show their performance against locally agreed metrics, in addition to data provided to the Care Quality Commission for registration purposes.

CQUIN (Commissioning for Quality and Innovation) is envisaged as a "pay for performance" scheme by which PCTs hold back a percentage (envisaged as 2%) of the contract sum from providers. This is released when the Provider Trust delivers a number of pre-agreed quality improvements – anticipated as delivery of a specific level of performance against various metrics. While this level seems low, Monitor¹⁴ suggests 5% is sufficient to bankrupt an institution so 2% could provide sufficient leverage and incentive.

¹⁴ Regulatory body for NHS Foundation Trust

7.3.7 Competencies, skills and behaviours

World class commissioning competencies

Of the 11 competencies identified by the DH in *World Class Commissioning: Competencies* (2007), six have obvious relevance to real-time patient feedback.

These are shown in Box 14 below.

Box 14: World class commissioning competencies

Number	Competency
1	Recognised as the local leader of the NHS
2	Works collaboratively with community partners to commission services that optimise health gains and reductions in health inequalities
3	Proactively seeks and builds continuous and meaningful engagement with the public and patients, to shape services and improve health
4	Leads continuous and meaningful engagement with clinicians to inform strategy, and drive quality, service design and resource utilization
8	Promotes and specifies continuous improvements in quality and outcomes through clinical and provider innovation and configuration
9	Effectively manages systems and work in partnership with providers to ensure contract compliance and continuous improvements in quality and outcomes

However, given our assertions in Section 6 of the report about implementation of survey feedback, we suggest that there are five further competencies that would enhance commissioners' knowledge and skills:

Think whole systems

The reliance on providers for data collection and data provision suggests the need for collaborative working across organisational boundaries. Commissioners and Provider Trusts need to be working together with service users and citizens to bring patient experience and needs directly into the commissioning process. In addition, they should be developing partnerships with local authorities to develop common systems and technologies at population levels. To do this, commissioners need to be able to work effectively across organisational boundaries, building relationships and networks that will work for the whole system.

Be person centred

Bate and Roberts state that the key challenge to staff taking a patient centred approach would be to help users/patients involved "to design and develop a process that will lead to services being better in the user's terms" (2007:46). Central to this is developing the skills and modeling behaviours to focus on co-production between the organisation and staff (internal) and the user and stakeholders (external).

While commissioners will not be responsible for the direct design and provision of all services, they have a role in setting out their expectations of how Provider Trusts act to place users experience at the centre of what they do, and influence how services should be designed.

Design for human experience

Good service design is a core skill that is crucial to a patient centred approach. However, healthcare services have never explicitly engaged with *designing human experiences*, as distinct from designing processes.

Staff will need to develop their knowledge, skills and expertise in designing services, not only to be functional and work well, but crucially, to also be a good experience for service users on their own terms.

Ask the right questions

One of the key findings from both the literature and this study was the inability of staff to ask the right questions, and a focus on implementing technology. It is clear that much of the data gathered focuses on the ‘wrong’ questions; questions that are not determined by user need or experience, nor designed to elicit the data required for service improvement.

With commissioning focusing on a different agenda, consideration needs to be given as to what questions to ask at service level in real time that will enable commissioners to see trends and changes over time.

One important factor here is the need for training and development in evaluating services, and how to incorporate this into everyday practice. The SHA may wish to consider commissioning a series of workshops designed to skill up commissioners, PPI and communication leads and those with responsibility for service improvement, to design appropriate evaluation strategies. This could incorporate recommendations from Bate and Roberts (2007) to ensure some of the more innovative methods such as visual, tactile, exploratory, expressive and creative methods are included.

Embed equality into everyday practice

Equality impact assessments (EIAs) provide a systematic way to ensure legal obligations are met and are also a practical way of examining new and existing policies and practices, to determine what effect they may have for those affected by the outcomes in terms of equality.¹⁵

By ensuring that equality is embedded within their objectives from the outset, EIAs will assist commissioners to achieve their business objectives and enable organisations to identify problems and make the necessary changes.

¹⁵ <http://www.nhsemployers.org/excellence/excellence-1871.cfm>

Staff will need to develop the skills and competencies to undertake EIAs in order to understand the functions of an organisation and the way decisions are made.

7.4 Two questions and one caution

No doubt there are a multitude of questions which remain unanswered and which need to be discussed, debated and potentially decided upon.

7.4.1 What will trigger action and change

For the authors, there are two important questions that remain unanswered:

- Are organisations willing to take the risk and be prepared to innovate in the absence of robust research evidence about whether real time patient feedback makes a difference; and
- What would be a significant enough response rate for an organisation to act upon and invest in making changes - if one person makes a comment, if 10 people make the same comment, if 50 make the same comment?

With large-scale patient surveys, it was always expected that a large number of patients reporting problems would be sufficient to trigger action, with systems such as *Problem Scores*¹⁶, developed by the Picker Institute, helping to systematically analyse and prioritise. However, this never really happened and one reason why is that organisations often argued that the data was out of date.

This, in part, is where the drive for real-time has come from. But the sample sizes for real-time feedback are likely to be much smaller. So will it now be magnitude of problems (rather than sheer numbers) that count or something else?

7.4.2 Human services require human relationships

The development of new technology is providing innovative and enabling ways in which the human services such as health and social care can be more person-centred, responsive and improve the quality of care. However, there is a danger that technological solutions will become a proxy for human contact. Highest on the list of complaints from patients about their care is how they are treated by people, with a lack of respect and dignity cited as key issues. Embedded in a lack of respect or dignity is the lack of relatedness.

Menzies-Lyth's research (1988) showed that over time, nurses developed ways of defending against the anxieties inherent in the nature of their work, by introducing routines, systems and procedures that took them away from having to relate with patients' experiences. She suggested that this develops over time through collusive interaction and agreement, and is often unconscious.

Real-time patient feedback has limitations, not least because much of the methodology can only gather responses to 'what' questions. The 'why' and 'how'

¹⁶ the higher the score the more important it is to address the issue

questions require face-to-face methods to drill down and understand the experience of the individual. Technology has an important part to play, but its introduction needs to be thought through carefully to ensure that those providing direct care for patients don't see themselves just as suppliers to a customer.

8 References

- Audit Commission (2001) *Change Here*, London: HMSO
- Aveyard H. (2006) *Doing a Literature Review in health and social care – a practical guide*. Open University Press 2006
- Bate, P. and Robert, G. (2007) Toward a More User-Centric OD, in *The Journal of Applied Behavioural Science*, Vol 43, No. 1 March 2007 pp 41-66
- Baumgartel, H. (1959) Using Employee Questionnaire Results for Improving Organizations: The survey (Feedback) Experiment, *Kansas Business Review*, 12 pp 2-6
- Bennis, W. G., Benne, K. D., & Chin, R. (1961) (Eds.) *The planning of change*. New York: Holt, Rinehart & Winston.
- Block, P. (2000) *Flawless Consulting*, San Francisco: Jossey-Bass
- Blyth B. (2008) *Mixed mode: the only 'fitness' regime?* *International Journal of Market Research*, 50, 2, 241-266
- Bowling A. (2002) *An "inverse satisfaction law"? Why don't older patients criticise health services?* *Journal of Epidemiology and Community Health*, 56: 482.
- Boyd J. (2007) *The 2006 Inpatients Importance Study*. Oxford: Picker Institute.
- Breen D, Donnelly R D, Chalmers J. (1992) *Finding out what the customer wants: Computer-Assisted Telephone Interviewing (CATI)?* *International Journal of Health care Quality Assurance*; 1992; 5, 3
- Brennan M, Benson S and Kearns Z. (2005) *The effect of introductions on telephone survey participation rates*. *International Journal of Market Research*, 47, 1, 2005
- Bridges, W. (2003) *Managing Transitions: Making the Most of Change*, London: Nicholas Brealey Publishing
- Bronner F and Kuijlen T. (2007) *The live or digital interviewer – A comparison between CASI, CAPI and CATI with respect to differences in response behaviour*. *International Journal of Market Research*, 49, 2 167-190
- Broussine, M. and Vince, R. (1996) Working with metaphor towards organizational change, in Oswick, C. and Grant, D. *Organization Development: Metaphorical Explorations*, London: Pitman pp 57-72

The Cabinet Office (2008) *Customer Service Excellence: The Government Standard*. London: The Cabinet Office

The Cabinet Office (2008) *Excellence and Fairness: Achieving World Class Public Services*: The Cabinet Office

Calman L. (2006) *Patients' views of nurses' competence*. *Nurse Education Today*, 26 (8): 719-25.

Care Quality Commission (CQC) (2008) Press release dated 24th October 2008. CQC website 12/11/08

Cavanagh M and Grant A (2005) *Brief cognitive behavioural solution focused coaching: models, tools and techniques for change* (unpublished workbook)

Clever S. et al (2008) *Does doctor-patient communication affect patient satisfaction with hospital care? Results of an analysis with a novel instrumental variable*. *Health Services Research*, 43 (5): 1505-19.

Coulter A. (2006) *Can patients assess the quality of health care?* *British Medical Journal*, 333: 1-2.

Coulter A and Ellins J. (2006) *The quality enhancing interventions project: patient-focused interventions*. London: The Health Foundation.

Comley P. (2008) *Online research communities – a user guide*. *International Journal of Market Research*, 50, 5, 2008

Crosby, P. (1979) *Quality is Free : The Art of Making Quality Certain*, McGraw-Hill, New York

Cummings, T.G. and Worley, C.G. (2001) *Organisational development and change* 7th edition, Cincinnati, South-Western College Publishing

Davidson, D. and Vick, N. (2002) *Beyond Involvement: Making Choices and Taking Control*, *Mental Health Review*, 7, 2, 25-28

Davies E and Cleary P D. (2005) *Hearing the patient's voice? Factors affecting the use of patient survey data in quality improvement*. *Quality and Safety in Health Care* 2005; 14; 428-432

Deming, E. (1986) *Out of the Crisis*, Massachusetts Institute of Technology, Boston MA

Dent, E.B. and Goldberg, S.G. (1999) *Challenging 'Resistance to Change'*, in *The Journal of Applied Behavioural Science*, Vol 35, No. 1 March 1999 pp 25-41

Department for Education and Skills (2003) *The Skills for Life survey. A national needs and impact survey of literacy, numeracy and ICT skills*. London: DfES

DH (2004) *Standards for Better Health*. London: Department of Health

DH (2005) *Public attitudes to self care – baseline survey*. London: DH.

DH (2007) *World Class Commissioning – Vision Summary*. London: DH

DH (2008a) *High Quality Care For All: NHS Next Stage Review Final Report*. London: Department of Health

DH (2008b) *Real Involvement*. London: Department of Health

DH (2008c) *Measuring for Quality Improvement: the approach*. London: Department of Health

Duffy B, Smith K, Terhanian G and Bremer J. (2005) *Comparing data from online and face-to-face surveys*. *International Journal of Market Research*, 47, 6, 2005

Entwistle V A et al (2003) *Public opinion on systems for feeding back views to the National Health Service*. *Quality and Safety in Health Care* 2003; 12; 435-442

Eysenbach G et al (2004) *Health related virtual communities and electronic support groups: systematic review of the effects of online peer to peer interactions*. *BMJ* 2004; 328: 1166

Fudge N. et al (2008) *Assessing the promise of user involvement in health service development: ethnographic study*. *British Medical Journal*, 336: 313-17.

Fung C. (2005) *Patients' preferences for technical versus interpersonal quality when selecting a primary care physician*. *Health Services Research*, 40 (4): 957-77

Gaucher, E. and Coffey, F. (1990) *Transforming Healthcare Organisations*, Jossey-Bass, San Francisco, CA

Gilbert, David (2008) *The E-cycle*. Email communication: InHealth Associates

Greenhalgh, T. and Peacock, R. (2005) *Effectiveness and efficiency of search methods in systematic reviews of complex evidence: audit of primary resources*. *British Medical Journal* 331: 1064-5

Hoyle, L. (2004) *From sycophant to saboteur: responses to organisational change*, in Huffington, C. Armstrong, D. Halton, W. Hoyle, L. and Pooley, J. (2004) *Working Below the Surface: The Emotional Life of Contemporary Organizations*, Tavistock Clinic Series, London: Karnac pp 87-106

- Huberman M. (1987) *Steps toward an integrated model of research utilization*. Knowledge: Creation, Diffusion, Utilization 8 (1987): 568-611
- Hughes, M. (2004) (ed) *Enabling Choice: A Report to the Local Government Association*, University of Birmingham, School of Public Policy
- Ipsos MORI (2008) *Real Time patient feedback - information patients need and value*. London. Ipsos MORI
- Jones R. (2008) *The role of health kiosks. A rapid review for NHS Choices*. Plymouth: University of Plymouth.
- Kennedy I. (2008) *Sir Ian Kennedy on the future of the annual health check*. HSJ website published 12/11/08
- Kubler-Ross, E. (1973) *On Death and Dying*, London: Routledge
- Labarere J et al (2001) *Development of a French inpatient satisfaction questionnaire*. International Journal for Quality in Health Care 2001: 13, 2: 99-108
- Large, S., Cunningham, G., Macleod, A., and Kitson, A., (2005) *A Multiple Case Study Evaluation of the RCN Clinical Leadership Programme in England*. London: Royal College of Nursing
- Lurigio, A.J. and Skogan, W.G. (1994) *Winning the Hearts and Minds of Police Officers: An Assessment of Staff Perceptions of Community Policing in Chicago*, in *Crime and Delinquency*, Vol 40, No.3, July 1994, pp 315-330
- Mann, F. (1957) *Studying and creating change: A means to understanding social organization*. Research in industrial relations. Ann Arbor: Industrial Relations Research. Association, Publication No. 17
- Marris, P. (1974) *Loss and Change*, London: Routledge
- Medical College of Georgia (2008) *Physician's 'Dashboard' Takes a Measure of Communication Skills*. Science Daily 6th October 2008 (Retrieved from internet November 19th 2008)
- Menzies-Lyth, I.E.P. (1988): *Containing anxiety in institutions: Selected Essays*, Volume 1, London: Free Association Books
- Morrison D S, Thomson H and Petticrew M. (2003) *Effects of disseminating research findings on response rates in a community survey: a randomised controlled trial*. Journal of Epidemiology and Community Health 2003; 57; 536-537
- Nelson E C et al (1991) *The Patient Comment Card: A System to Gather Customer Feedback*. Quality Review Bulletin, 17, 9, 1991

Neumann, J. E. (2007). *Applying Design Rules for Whole Systems Intervention*, University of Birmingham's MSc in Leading Public Service Change and Organisational Development

NHS West Midlands (2007) *Investing for Health – A Strategic framework for the West Midlands*. Birmingham: NHS West Midlands

Office of the Deputy Prime Minister/Treasury (2005) *Securing better outcomes: developing a new performance framework*. London: OPDM

Office for National Statistics (2008) *Internet access 2008: households and individuals*. <http://www.statistics.gov.uk/pdfdir/iahio808.pdf>.

Ovretveit, J. (2005) Leading Improvement, in the *Journal of Health Organization and Management* Vol 19, No. 6, pp413-430

Picker Institute Europe (2003) *A Guide to sharing your survey results*. Oxford: Picker Institute

PricewaterhouseCoopers (2008) *Strategy for Customer Experience Information in Health & Social Care (Draft)*. London: PricewaterhouseCoopers

Richardson A, Charny M and Hanmer-Lloyd S (1992) *Public Opinion and purchasing*. *BMJ* 1992; 304:680-2

Samli, A.C. (2001), *Empowering the American Consumer: Corporate Responsiveness and Market Profitability*, Quorum Books, Westport, CT.

Sheldon H and Rasul F. (2006) *Increasing response rates amongst BME and other hard to reach groups – a review of the literature relevant to the national acute patients' survey*. Oxford: Picker Institute.

Schillewaert N and Meulemeester P (2005) *Comparing response distribution of offline and online data collection methods*. *International Journal of Market research*, 47, 2, 2005

Seligman, M.E.P. (1972). Learned helplessness. *Annual Review of Medicine*, 23, 407-412.

Smith G. (2005) *Beyond the ballot: 57 democratic innovations from around the world*. London: The Power Inquiry.

Spandler, H. (2004) Friend or foe? Towards a critical assessment of direct payments, in *Critical Social Policy*; 24; 187 – 209

Staniszewska S and Henderson L. (2004) *Patients evaluations of their health care: the expression of negative evaluation and the role of adaptive strategies*. *Patient Education and Counselling*, 55: 185-192

Staniszewska S and Henderson L. (2004b) *Patients' evaluations of the quality of care: influencing factors and the importance of engagement*. *Journal of Advanced Nursing*, 49 (5): 530-37.

Tasa K, Baker G R and Murray M. (1996) *Using Patient Feedback for Quality Improvement*. *Quality Management in Health Care*, 1996, 4 (2), 55-67

Vingerhoets E, Wensing M, Grol R. (2001) *Feedback of patients' evaluations of general practice care: a randomised trial*. *International Journal for Quality in Health Care* 2001; 10: 224-8.

Wensing M, Vingerhoets E, Grol R. (2003) *Feedback based on patient evaluations: a tool for quality improvement?* *Patient Education Couns* 2003;51: 149-53.

Wright D, Aquilino W, Supple A. (1998) *A comparison of computer-assisted and paper and pencil self-administered questionnaires in a survey on smoking, alcohol, and drug use*. *Public Opinion Quarterly*, 62:331-353 1998

6, P. (2003) 'Giving Consumers of British Public Services More Choice: What can be learned from Recent History?' *Journal of Social Policy*, 32: 239-270

Key themes from Literature Search – Section 1 Database Search

Article	Author	Date Published	Methodologies				Use of Feedback	General
			Face-to-face interviews	Self administered paper questionnaire/ Feedback forms/ Comment cards	Computer Assisted Telephone Interviewing (CATI)	Computer Assisted Self-Interviewing	Online panels	
Are responses to health and lifestyle questions similar in telephone owners compared to non-telephone owners – can Computer Assisted Telephone Interviewing (CATI) be representative	D Breen, R Donnelly, J Chalmers	1992	Expensive method – requires time and training	Poor and slow response rate with postal questionnaires	Reduces errors as responses keyed into computer Results analysed quickly and continuously Home telephone ownership significantly lower in low income households Uptake of preventative services lower in non-home telephone households CATI gives unrepresentative answer to questions such as smoking prevalence CATI under representation in socio-economically disadvantaged households – acceptable where precision of result not required			
Effects on survey response rates of providing research feedback	D S Morrison, H Thomson, M Petticrew	2003		Response rates to postal questionnaires declining No evidence that providing feedback on research will increase response rates – may even reduce response rates in spite of additional cost				

Use of questionnaire to obtain representative public opinion on health services	A Richardson, M Charny, S Hanmer-Lloyd	1992						Public doesn't necessarily have same priorities and values as commissioners – may value reducing mortality and investment in life-saving interventions rather than reducing morbidity	
Developing a self-administered questionnaire	J Laberre et al	2001							<p>Patient perception is predictive of future behaviour (compliance with treatment)</p> <p>Patient satisfaction is an abstract concept</p> <p>Questionnaires often describe respondents replies to questions devised by researchers and don't consider what matters most to patients</p> <p>U-shaped relationship between length of time after episode of care and patient satisfaction – i.e. high initially, then drops, then increases again</p>
How coverage issues of modality will effect results	Bill Blyth			Better responses for sensitive questions and to avoid effects of social desirability and lower item non-response	Decline in terrestrial telephone coverage in favour of mobile technology Coverage lower than acknowledged – 13% adults over 15 have no fixed line home phone	Better responses for sensitive questions and to avoid effects of social desirability and lower item non-response Coverage of internet lower than acknowledged – 64% coverage for 15-24 age group but only	Recruiting panel members from non-home computers may encourage behaviour against terms and conditions of computer usage at work or school/college etc		Restriction of survey to any mode other than face-to-face will exclude distinctive sub-groups of population

Comparison between different methods and response behaviour	F Bronner and T Kuijlen	2007	<p>Moderating effect of interviewer – less reporting of personal or emotive issues If interviewers paid by interview, may rush through questionnaire</p> <p>Evaluation apprehension – respondents present themselves as better or smarter when they think they are being evaluated</p>		<p>Moderating effect of interviewer – less reporting of personal or emotive issues Less opportunity to provide detailed answers Respondents more likely to give extreme point on scale answers Respondents less likely to give 'don't know' responses</p> <p>Evaluation apprehension – respondents present themselves as better or smarter when they think they are being evaluated</p>	<p>35% for 55+</p> <p>CASI allows for complex routing of questions Interviewer effects removed - less inhibited responses Less distortion by socially desirable responses More mental health issues reported Can provide detailed answers Respondents more likely to give mid-point on scale responses Respondents more likely to give 'don't know' responses Can use graphical pictures within survey Respondents choose when to respond – more time to deliberate and reflect</p>	<p>Members choose when they want to participate – increases response rate Quality of panel depends on recruitment and maintenance Members should be recruited randomly – not via internet or volunteers</p>		
Comparison between online and face-to-face	B Duffy and K Smith	2005	More susceptible to social desirability bias		<p>Landline coverage dropping – 7% of households have no phone or mobile – young households likely to have mobile only</p>	<p>By Feb '05, 59% GB adults had used internet Possible to accumulate large volumes of data in short space of time but minimum time period must still given for an online questionnaire to ensure good coverage Avoidance of interviewer effects Higher admission of undesirable behaviour online</p>	<p>Online panel – faster and cheaper Those that sign up for panels – younger and more male profile Attracts more knowledgeable, 'viewpoint' orientated sample than face-to-face</p>		

						<p>Disease prevalence rates closer to know rates when using internet as opposed to telephone or face-to-face</p> <p>More convenient for people to complete</p> <p>Online surveys reach educated and well off who may not respond to cold callers</p> <p>Online respondents more likely to have active opinions and account for different attitudes online</p> <p>Sampling issues as a large part of population is excluded at outset as no access to internet</p> <p>Online users use midpoints of scale rather than extremes</p> <p>Respondent fatigue more evident in online as no interviewer to give encouragement – first drop-off rate = 18 mins</p> <p>Online respondents generally better informed than face-to-face samples</p> <p>Certain questions inappropriate to answer online i.e. use of technology</p>			
Effects of telephone survey introductions to increase participation rates	M Brennan, S Benson Z Kearns	2005			<p>Key to high participation rate – skill of interviewer</p> <p>Offering to provide research results at a later stage doesn't increase response rates</p> <p>Prepaid monetary</p>				Response rates falling across all forms of research

					incentives can increase rates but not practical in large scale random digit dialling – could use prize draw/lottery Assurance of confidentiality – a negative effect – may seem as though survey is more sensitive than it is Combination of ‘no sales’ assurance and incentive increased response rates slightly				
Comparison between postal, telephone and online data collection	N Schillewaert	2005		Response rates for this study with mailed questionnaire – 31% Mail generated older respondents Respondents to postal survey had lowest education and more likely to be blue collar	Incomplete penetration for telephone interviewing becoming more apparent Response rates for this study with random digit dialling – 35%	Online research faster and cheaper No interviewer bias Completed at respondents convenience, therefore less intrusive Fewer errors in data entry Larger sample size Can build in personalisation, graphics, question branching, routing Problem with external validation, if research question relates to a population where level of internet penetration doesn't match distribution of focal population Response rates for this study with pop ups on high volume websites – 10% Pop-ups generated younger respondents but also respondents with lowest internet connection at home so accessing via work	Easier to stay in touch with people over long periods of time for longitudinal research Response rates for this study – 52%		All survey methods suffer from self selection to some extent Samples by whatever means result in different outcomes and different profile of respondents

						or school/college			
Comparison in obtaining self-reported substance abuse and psychological well-being through CASI and self administered paper questionnaire	D Wright, W Aquilino and A Supple	2001		Anonymity increases respondents willingness to report sensitive information SAQ's provide higher estimates of substance use than interviewer administered questionnaire Data errors and non responses higher Paper and pen limits complexity of questionnaire i.e. branching CASI and paper SAQ equally effective in yielding sensitive data		Anonymity increases respondents willingness to report sensitive information SAQ's provide higher estimates of substance use than interviewer administered questionnaire CASI can increase data quality Flexibility of questionnaire design and personalisation Attitudes towards data confidentiality and use of computers can affect participation Greater acceptance of method from those with positive attitude towards their use – school/ work etc Effects of computerization less dramatic on reports of sensitive behaviour than self administration over interviewer administered Adolescents more likely to report highly sensitive information in CASI form than pen and paper Use of CASI in lower status households requires further investigation because of coverage issues CASI and paper SAQ equally effective in			Mistrust of others influences survey responses

						yielding sensitive data			
Use of patient comment card in US hospitals compared to mailed random questionnaire	E Nelson et al	1991		<p>Response rates in this study – 17% for mailed method, 28% where comment cards handed out</p> <p>Response rates lower than professionally administered questionnaire employing follow up methods (61% response rate)</p> <p>Briefer the questionnaire – higher the response rate</p> <p>Factors such as personalisation, research sponsorship, confidentiality, appearance of forms, use of data and incentives can all influence response rates</p>				<p>If goal to gather feedback or gain general information, to offer every patient opportunity to feed back or identify those who are dissatisfied, brief questionnaire may suffice but if goal to measure quality with reliable and valid indicators, need to invest more robust methods to ensure increased response rates</p> <p>Patient feedback is a powerful motivator for change</p>	
Using patient feedback - case study of US teaching hospital	K Tasa, R Baker and M Murray	1996						<p>Use enhanced when measures readily accessible to users, feedback is timely and actionable , when users know how to interpret and analyse feedback and when a mix of flexible and standard indicators</p> <p>Individuals can be selective about interpreting results, accepting results that support preconceived notions and rejecting responses that don't</p> <p>Characteristics of</p>	<p>Before using quantitative instruments, use qualitative first to explore areas of interest</p> <p>Patient satisfaction questionnaires can pinpoint problem areas but won't identify root cases</p> <p>Complaint/ compliment system valid but considered unreliable as produce extremes of response</p> <p>Repeated exposure to patient feedback can alter ingrained</p>

								<p>data (whether linked to processes), characteristics of organisation (is it a learning organisation or blame culture?), characteristics of individuals (scepticism) can all be barriers to effective use of data</p> <p>Use of feedback as basis for strategic planning i.e. focusing on specific areas such as cleanliness, staff attitude, communication etc</p> <p>Info from questionnaire more useful at strategic than operational level as measure dimensions of care rather than specific processes</p> <p>Most important factors influencing effective use of patient feedback are: top level commitment, resources, existing process improvement knowledge, organisational culture and existence of a strategy for using feedback</p> <p>Translating needs and expectations of patients into process improvements extremely complex</p>	clinical attitudes and behaviours
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								Quantitative scales by organisational level cover a broad focus and are best used at strategic level to steer organisations strategic planning Senior managers comfortable with numerical data and consultancy reports, front-line staff prefer verbal/visual and graphical representations As feedback doesn't take form of recommendations, high degree of flexibility in interpretation Staff who lack skills, attitudes, support and time to use feedback will not do so	
Public opinion on different methods for providing feedback – Scottish study	V Entwistle et al	2003	US and Australian hospital use system of patient representatives (PRs) to listen to and solicit feedback from patients In study 80% respondents were optimistic about use of patient representatives – older people more likely to prefer this method PRs seen as independent and objective and on patient's side but knowledgeable about systems PRs can provide	Feedback forms – easy and convenient – can provide feedback in non-confrontational way Existence of forms suggests organisation takes feedback seriously	Telephone comments line – easy and accessible can use at own convenience and have direct personal communication Over a third of respondents in study though dedicated phone line would be a waste of money Central telephone line for feeding back general issues to highlight tends and whole system concerns System would need careful explanation to people and publicity to manage people's expectations of what it	Feedback website – ease and convenience and speed plus wouldn't take up valuable NHS staff time and anonymous Over a third of respondents in study though dedicated website would be a waste of money Website for feeding back general issues to highlight tends and whole system concerns System would need careful explanation to people and publicity to manage		Preference for using different methods depending on nature of feedback – whether complaint, general comment etc Preference for anonymous systems – people reluctant to express concerns openly for fear of compromising their care Range of methods desired to cater for different needs and personal	

			prompt personal attention for those experiencing problems and to initiate local quality improvements		was for and what it could deliver	people's expectations of what it was for and what it could deliver			preferences but potentially costly, so some prioritisation required
Exploration of use of online communities	P Comley	2008					Use of online communities increasing Usually for qualitative insight though quantitative and polls run through them Building online communities difficult and time consuming initially – requires expertise and regular monitoring and maintenance Easier where groups share a common interest or concern – i.e. disease specific or new parents etc. Terms and conditions important for all users to abide by People contribute more when they know who they are speaking to and responses can be a third higher if sites are branded Can use chat sessions with key officers from organisation Contact required		Response rates for traditional methods declining and public expectations of research and polls changing

							<p>at least weekly with community</p> <p>Online communities typically smaller than online panels – 300-500</p> <p>Need to refresh and replace inactive members</p> <p>Women more frequent contributors</p> <p>Those who contribute more frequently can be more brand loyal</p> <p>More fun to take part than traditional methods</p> <p>Higher convenience factors</p> <p>Ongoing – respondents can see what's changing and continue to respond</p> <p>Can generate large volumes of data – can cause problems unless systems set up to manage this</p> <p>Wary of conditioning effects on members – they become less representative of whole population</p> <p>Greater honesty of response</p> <p>Costs for real-time translation into other languages</p>		
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							may be prohibitive Need to supplement with other methods May risk alienating those who don't take part		
Understanding factors affecting use of patient survey data in quality improvement	E Davies and P Cleary	2005						<p>No published evidence that feedback leads to sustained improvements</p> <p>Randomised trial of providing survey results to 55 GPs in Netherlands found no effect on patient evaluations of their care a year later – study found that despite motivation, GPs found it difficult to use patient evaluations and became sceptical of their value</p> <p>Effective response to feedback requires prior development of quality improvement structures, capacity and skills</p> <p>Lack of access to statisticians and database designers in NHS impedes progress</p> <p>Use of survey data to challenge traditional ways of working – clinical scepticism</p> <p>Qualitative could be viewed more positively than quantitative by</p>	<p>Younger patients, those with low incomes, poor perceived health and non-black ethnic minorities report worse experiences</p> <p>Lack of emphasis on patients' needs in decision making make it difficult to create right culture for change</p> <p>Are high scores a result of patient gratitude rather than actual satisfaction?</p> <p>Surveys in themselves do not indicate what needs to be done, further commitment and effort required to interpret and develop solutions</p>

								<p>clinicians who may often query whether quantitative is statistically significant</p> <p>Long delay from data collection to analysis to feedback – a major limitation I</p> <p>patient feedback usage</p> <p>Data re: a general problem or satisfaction rather than a specific care process, difficult to interpret and act upon</p> <p>Time delay form data collection to feedback to intervention makes it difficult to infer what has caused what</p> <p>Research on effectiveness of using survey data is limited however structural process for addressing problems and obtaining resources critical in addressing issues raised</p>	
The impact of positive and corrective feedback on customer service performance	R Waldersee and F Luthans	1994						<p>Study involving giving of positive and 'corrective' feedback to 111 employees in 11 fast-food restaurants on aspects of customer service in US (very routine tasks). Results show positive feedback did</p>	

								not improve performance. Control group improved significantly more than group given positive feedback. Corrective feedback group did not perform significantly differently to control group - consistent with Closed-Loop model of self regulation.	
Turning Customer Input into Innovation – focus on outcomes not specific solutions	A Ulwick	2002						Instead of asking customers what new products or services they want, research should focus on the outcomes customers want. Asking customers for solutions undermines the innovation process. Customers have a limited frame of reference - they only know what they have experienced – functional fixedness.	

Section 2 - International, public and industry sector examples

International Healthcare Organisations

- **Planned Parenthood Mohawk Hudson (US)** – uses Opinionmeter. Wanted direct patient feedback but a paper survey was considered inconsistent and not eco-friendly. Currently use touch screen kiosk devices in largest clinic sites in waiting rooms to gauge patient satisfaction as well as informing patients of special programmes available to them. Data collected is being used to evaluate quality of care, convenient hours for patients, and level of customer service. Also used devices for community events. (From internet search)
- **Saint Francis Heart Hospital (US)** – random sample of discharged patients surveyed each week by telephone. Survey results presented monthly to staff and management. (From internet search)
- **Melbourne Health Consumer Panel** – Community Relations Team 039342 7760 consumers@mh.org.au. 35 people on panel – focus groups, projects and committees. Panel members involved in development of organisation's service plan (both acute and community organisation) (From internet search)

Other public sector

- **Southampton City Council, Leisure Services** – CRT Viewpoint. Existing comment card and website methodologies generating limited responses, which were difficult to quantify. **Touch screen devices placed at 'point of service' areas in art galleries, museums, tourist information centres, libraries etc. Also using to recruit customers who 'fit the profile' for Customer Focus Groups.** (From interview with supplier)
- **Leeds City Council /Metro** – travel survey – rail, bus, road users to help plan for future transport needs – updates traffic module every 2-3 years. Survey carried out by Jacobs Engineering UK Ltd. For rail users – on one day only, questionnaires handed out as travellers come off platforms – can either post or complete and put in drop boxes in station – completed surveys entered into a free prize draw, generated 20% response rate. Road and bus surveys over two months – survey on respondent's journey that day – each bus route and major road links – roadside surveys. Also household face-to-face surveys. (From interview with supplier)
- **Hertfordshire County Council** - Programme of improving customer feedback – vox pops filming, mystery shopping, Viewpoint Touch screen Interactive questionnaires. (From internet search)

- **Nottingham County Council** – website feedback – traffic light smileys on each page. Visitors to website rate about 2,000 pages each month – nearly 60% rates as good but 30% as poor. Provides some examples of how services have changed based on feedback. (From internet search)
- **Warrington Borough Council** – Launched new citizen feedback service in Jan 2008. Developed with Northgate Information Solutions, to collate, and analyse information to inform development of personalised services. Also to be used to track issues and resolve problems. (From internet search)

Industry and private sector

- **The Mandarin Oriental Hotel** - Management receive daily updates on each new guest – meeting of up to 20 people – each customer has a profile with preferences - multidisciplinary ‘ward round’? **(from SHA Customer Experience briefing notes)**
- **Radisson Hotels** – 155 hotels
According to website, the Group provides a 100% guest satisfaction guarantee. Feedback form is available for guests to complete on website. (From internet search)
- **Ibis Hotels** – 700 hotels
Provides a quality commitment (published on website) – if a guest experiences a problem, hotel will resolve it to guest’s satisfaction within 15 minutes, or the room is free. Also comments form available on website. (From internet search)
- **London Underground** – CRT Viewpoint. Stations required to undertake surveys at stations as part of Secure Station Scheme run by Department for Transport. Previously used face-to-face interviews but costly and timely. Touch screen device attaches to existing customer information whiteboards. Generated approx 700 responses per fortnight. Surveys cost approx 30p per response. Surveys measure feedback on local and tactical issues. (From interview with supplier)
- **ASDA** – CRT Viewpoint. First phase - touchscreen devices in 100 stores. Now have a mobile van with touch screen devices installed, which goes round stores. (From interview with supplier)
- **Specsavers** – CRT Viewpoint. 200 touchscreen devices which company rotates every four months through its 650 stores. Different language surveys on devices, respondent chooses preferred language on entry screen. (From interview with supplier)

- Cadbury World – CRT Viewpoint. Wanted substantial amounts of feedback to put together ‘customer profiles’ based on geographical location and age. With results planned to pinpoint improvements and changes to advertising. Previous face-to-face survey, lengthy and costly and only 200 respondents. Use touch screen devices and gather 700 responses a week – has halved research costs. Led to better understanding of customer and has re-focused their advertising strategy. Survey pinpointed products and activities customers want which has enabled them to re-focus merchandising too. (From interview with supplier)
- **Leicestershire Constabulary** – CRT Viewpoint. Previously conducted ‘expensive’ mystery shopper programmes and contacted people by telephone using outsourced service and purchasing ‘costly’ contact lists. Touch screen devices placed in entrance halls and waiting areas at 6 police stations for 10 days at each site. Survey to collect opinion on the service and environment. Devices also put in local retail stores to gather community attitudes to policing. Each station gathered approx 100 responses over 10-day period. Placements in supermarkets gathered higher response rate. (From interview with supplier)
- **John Lewis** (from SHA Customer Experience briefing notes)
Mystery Shopper Programme
- **ARGOS** – using touch screen devices for real-time satisfaction surveys. Devices placed in 140 stores from December ’08. Plans to place them in all 700 stores between March and September ’09. Supplier is CFS Europe. Also supplements with online survey. (From database search)
- **Boots** – additional receipt handed to shopper with purchases, providing an email address and telephone number to call to complete a customer satisfaction survey. Unique code on receipt to provide to be able to enter survey – opportunities to win a prize by completing. Survey used is Empathica – used by drug stores, retail banking, quick service restaurants, supermarkets etc. – by internet and text. (From interview with organisation)
- **CITIBANK** – Uses Empathica multi-mode survey since 2006– touch screen kiosks, telephone and internet. Initially in 1,500 branches of bank in US and now in UK and 12 other countries – over 1700 locations and 1.08 million responses to date. Empathica has UK office based in Birmingham. (From database search)
- **Royal Mail website** – pop up box asking whether user will complete a questionnaire after using website. Multiple choice questions – about a dozen – with some free text. (From internet search)

- **Mail Online** – pop up box asking whether user will complete a survey re: their use of website and other media. Takes 8 minutes to complete and entered into a draw (10 Amazon or M&S £50 vouchers to win) (From internet search)
- **B&Q** – surveys on website usage and user opinion, feedback on specific products and post sales surveys on customer satisfaction. (from internet search)
- **Ford Financial Services** – monthly customer satisfaction surveys – tracking customers who have accessed financial services through dealership, once service has been concluded. (From internet search)
- Other motor industry examples - Impressions survey provided by Lepidus Ltd originally used in high-end automotive industry. Porsche's survey used 106 questions. Also used for Bentley and VW Group. (From discussion with supplier)

Appendix B



UNIVERSITY OF
BIRMINGHAM

Health Services Management
Centre (HSMC)

School of Public Policy

Org Type		National Survey to identify innovative systems, methodologies and technologies to obtain rich patient feedback on healthcare contacts on a real time or near to real time basis
PID		
Date		

Thank you for helping us with this survey consisting of only 12 questions, which forms part of a research study for the West Midlands Strategic Health Authority.

Please note this questionnaire is entirely voluntary, and is designed to help us compare and contrast different experiences from across the country, and from both commissioning and providing perspectives.

All the information that you give us is completely confidential and any information collected here (as elsewhere) will be used in a non-attributable way.

The questionnaire should take 30 minutes to complete.

Please answer all the questions.

A. Personal and organisational information

Name:.....

Job

Title:.....

Department:.....

Organisation:.....

Tel : (inc area code)

.....

Email:.....

B. Gathering feedback data

1. To what extent are local communities and people who use services, asked to give feedback on their experience of using local healthcare services? (*please describe current approaches in detail*)

2. Does your organisation use particular data sources, tools or techniques to gather data from local communities and people who use services?

3. For what purpose(s) is this data gathered and how is it used?
(Please describe all the current approaches in detail)

4. What level of investment is provided for this activity?
(Please describe all the current approaches in detail)

5. What challenges does the organisation face in gathering and using public/user feedback?

C. Implementation for change

On the 24th September 2008, Alan Johnson, Secretary of State for Health, made an announcement in which he called for a more patient centred NHS, stating that the income of 'hospitals' would depend on the outcome of treatment and quality of service to patients. Over the next 12 months every hospital trust will be expected to collect *immediate feedback* on hospital care in order to know within two weeks of treatment how patients felt about their care. The implication in this policy announcement is that real time feedback will be a mechanism for *providers* to collect data to demonstrate this and to improve the quality of existing services.

SHAs are working on an assumption that this data could also be used by PCTs to drive commissioning decisions. The DH is due to make a further announcement in this respect following a meeting with all SHA Chief Executives on 21st January, 2009.

6. Is your organisation currently using real-time feedback or planning to do so soon?

7. What methods of collection for real-time feedback, is the organisation using (or planning to use). Please tick all that are used:

a. Kiosks

Why is this being used?

b. Hand-held units

Why is this being used?

c. Patient line (bedside units)

Why is this being used?

d. Patient stories during/immediately after care experience

Why is this being used?

e. Point of care surveys

Why is this being used?

f. Other

Please specify below, and say why:

8. What implications will real-time feedback have for:
(Please explain in full and give examples where appropriate)

a. Service and quality improvement?

b. To drive commissioning

c. Delivering key policy objectives

(e.g. around World Class Commissioning, Patient and Public Engagement, Choice and Contestability).

9. What factors will help and hinder successful implementation of real-time patient feedback in your area?

10. What additional support would be helpful to implement real time patient feedback?

12. Do you have examples of local real time feedback good practice that would be of interest to other commissioning and providing agencies?

12. Are there any other comments or observations you would like to make?
(Please continue on a separate sheet if necessary)

THANK YOU, THE QUESTIONNAIRE IS COMPLETE

Please email your completed survey by 28th November 2008 to Jackie Francis at j.a.francis@bham.ac.uk.

Alternatively please post it to Jackie Francis, Projects Administrator, Health Services Management Centre, University of Birmingham, Park House, 40 Edgbaston Park Road, Birmingham, B15 2RT

