particularly useful as it showed that trusts would not be able to sample in line with the proposed approach because of IT issues, allowing appropriate changes to be made ahead of the survey proper.

Reviewing sample sizes

Effective sample sizes affect the precision of survey results, with larger numbers of respondents providing greater reliability where all else is equal. When calculating the required sample size, one must factor in the expected response rate, the level of precision desired, and the population size.

Since 2002, annual surveys within the NPSP have typically used an 850 sample size. This was calculated to detect year-on-year changes of ≥10% points in trust-results with 90% power at the 95% confidence interval. It assumed a 60% response rate: but over the last 15 years there has been steady decline in response rates on some of the national surveys (and more widely in market research). To keep the same precision, we would need to increase the total sample size.

For inpatients 2015, we have done this: the sample size has increased from 850 patients to 1,250 patients per trust, giving a national sample size of over 191,000 cases. This will not only provide more data to trusts, but also to CQC for Intelligent Monitoring. Importantly, it also makes sub-organisational comparisons – eg between hospital sites or demographic groups – feasible for many organisations.

For surveys that use a sample size of 850 cases and that achieve a lower response rate than inpatients, such as community mental health (28% response rate) and accident and emergency (36% response rate), it would be prudent to consider a similar increase in sample sizes. However, larger increases may be required than for the inpatients survey owing to these surveys historically achieving lower response rates. Although they offer improved reliability, progressively larger increases have two disadvantages. Firstly, increasing the sample size increases printing, postage, and data entry costs for participating trusts. Secondly, larger samples will only be possible where populations are large enough: for some surveys, the sample period may need to be extended to allow for a larger population from which to sample.

In summary: increasing the sample size for the patient surveys would enable more precise overall estimates and more detailed subgroup analysis to be undertaken for trusts and to CQC. It would also increase local costs and potentially require longer sampling periods. Consequently, we recommend that proposed changes are the subject of desk research and stakeholder consultation prior to implementation.

Design and development of the survey instrument

New and revised questionnaires for use in the national programme undergo a number of developmental stages that typically include stakeholder engagement and consultation, secondary analysis of existing survey data, and cognitive testing. For new surveys, or substantial redevelopments, questionnaire content is further informed by primary qualitative research in the form of focus groups and/or in depth interviews with patients and service users, along with desk research such as evidence scans or a comprehensive literature review.

Scoping and consultation

The first step in questionnaire design is a **scoping** phase where we consult with stakeholders to determine current policy, regulation, and improvement needs. For surveys that are being repeated with little or no change to questionnaire content, this would focus on speaking with key stakeholders at CQC and NHS England. For surveys undergoing substantial re-development this engagement would widen to include – for example – Department of Health, experts or practitioners in the current field, academics, NHS trust representatives, CQC Experts by Experience, and wider data users. Typically this consultation work would involve a combination of face-to-face and telephone meetings with key individuals. This approach was successfully adopted to re-develop the 2014 Community Mental Health Survey.

For new surveys, we will conduct **focus groups** and/or **in-depth interviews** to understand what service users see as the most important aspects of patient experience: an approach we implemented for the 2013 Hear and Treat Ambulance Service Users Survey. We will also conduct desk based research in parallel, including a broad evidence scan or in depth **literature review** to flesh out content.

Throughout this stage of the process we collaborate and discuss all content with CQC to ensure that the questionnaire is meeting their needs and they are comfortable with the proposed wording.

Analysis of survey data

Where existing survey data is available, we also undertake **secondary analysis** by analysing item non response, ceiling and floor effects and correlations between questions. This allows us to identify items that may not be 'working' in the way that we want either because respondents do not feel the question is relevant to them, or where a group of questions may be addressing a single underlying construct. Analysis of trust-level discriminatory power on items within the questionnaire is also useful to identify high-value topics/questions within each survey. We also review free text comments collected on the surveys to identify themes that are not currently reflected in the survey. For the 2015 Maternity Survey, for example, we identified that a high proportion of respondents commented on partners/ family members/ friends being unable to stay at the hospital with them following the birth: consequently, a new question item was added to this survey to address this issue.

Cognitive testing

Once a draft questionnaire has been developed and agreed, the next stage is **cognitive testing**. The purpose of cognitive testing is to test the construct validity of questionnaire items: in other words, to ensure that respondents understand what is being asked and are able to answer appropriately. In cognitive interviews, patients complete the questionnaire whilst observed and questioned by a researcher to confirm that their understanding of the questions are what the researchers intended. In doing this, we will consider the cognitive process of responding in terms of the model described by (Tourangeau, 1984), seeking to establish consistency in comprehension, retrieval, evaluation and response. Additionally, we will use the cognitive testing process as an opportunity to:

- check respondents can accurately follow the instructions within the survey;
- ensure that the questionnaire is relevant and salient; and
- identify any important omissions.

Cognitive testing will follow an iterative process, and the instrument will be checked and re-drafted as many times as necessary until no new information emerges. The number of interviews undertaken will thus vary dependent on the survey needs: for questionnaires with minor changes, three rounds of six interviews are normally sufficient. For substantially re-developed or new surveys, a greater number of interview may be required: for the 2014 children's survey we conducted 32 interviews (across 3 rounds) with both children and their parents/carers.

Recruitment methods for cognitive interviews vary depending on the needs of the research. We have successfully recruited via local media, across a number of geographical locations, and social media. For a number of national surveys we have tailored the recruitment strategy to better fit the population of interest. For the community mental health survey we recruited service users by attending local support groups run by Mind; we attended mother and baby groups at SureStart Centres for recruiting interviewees to test the Maternity Survey; and we recruited via hospitals for the Children's Survey. For patient groups that are more challenging to recruit, we have used specialist recruitment agencies.

Following cognitive testing a final questionnaire is agreed with CQC, circulated to wider stakeholders for comments and submitted for ethical review.

Ethical and safeguarding issues

All research undertaken at the Picker Institute is evaluated against our research ethics and governance framework. Surveys in the NPSP are usually classified as service evaluations – meaning that NHS ethical approval is not a strict requirement – but we seek voluntary ethical review of the surveys to demonstrate they adhere to best practice & protect patients' interests (The Market Research Society, 2014). Each survey is assessed as to whether the questionnaire content, accompanying survey materials and sampling method present any material ethical risk to participants. We have successfully obtained ethical approval for all surveys within the programme due to our knowledge and understanding of ethical considerations, and our experience of preparing these applications.

Ensuring respondent confidentiality is an important part of our work. Our approach to information governance and security is set out in the relationship management section, but some specific steps are taken around survey materials. We clearly and unequivocally communicate in letters that respondents will not be identified by the feedback they give and that participation is completely voluntary. We also re-iterate that the results of the survey will not allow for identification of individuals owing to the rules we apply in supressing data. On the questionnaire, where free text information is collected we include a statement highlighting to respondents that the information they provide in that section will be seen in full by the trust, researchers and the CQC. This is useful where there are concerns of a safeguarding or serious incident nature.

Survey implementation and delivery

Guidance and supporting materials

Surveys in the NPSP need to be standardised if they are to provide the quality of data required by stakeholders and regulators. To ensure this, we develop **survey materials and guidance** that trusts or approved contractors need to implement the survey. These documents are written in plain English and include strict and clear guidance on each step of the survey process.

As described in Figure 1, we see the surveys as following a process of continuous development and improvement. Continuous engagement with and gathering feedback from NHS trusts and approved contractors allows for identification of improvements to documents and survey processes. For example, since 2014, we have created three separate guidance manuals each tailored to the specific audience: one for approved contractors, one for NHS trusts using a contractor and one for NHS trusts implementing the survey themselves 'in-house'. This has made it easier for trusts, and contractors, to understand their responsibilities in undertaking the survey. For new or particularly complex surveys, such as the 2014

Children's Survey, we circulated draft versions of the guidance to a selection of trusts and all approved contractors to make suggestions for changes.

As highlighted sampling is particularly important. If the sample drawn is incorrect, it can result in a trust's data being excluded from national results and Intelligent Monitoring. To assist trusts with this, we provide:

- A tailored sampling **handbook** providing step by step instructions around drawing the sample and which patients to include/ exclude.
- A **sampling construction workbook** that details all the sample fields that need populating with data and in the correct format.

In future, we would recommend making greater use of practical tools to support those drawing samples. For example, for the 2012 Accident and Emergency survey we created an Excel sampling workbook that would identify exactly which patients should be included in the systematic sample. Trusts populated the workbook with their population data and the workbook made the selection for the trust: this ensured accurate systematic sampling. This approach could be extended to other surveys.

Sample checking

When fieldwork begins, samples drawn by trusts are submitted to the co-ordination centre for checking: an approach we introduced in 2006 to identify major errors that would prevent a trust's data being included.

We employ a sophisticated process to check samples. Submitted samples are collated and demographic details from each trust's submission – age distributions, dates of admission and discharge, and so on – are compared to a) expected ranges; b) comparative data from other trust samples; and c) historic data from the same trust. Bespoke and regularly updated software is used to facilitate this process, minimising staff time and ensuring value for money. This approach enables us to detect the vast majority of serious issues before questionnaires are distributed.

When errors are identified, we work with trusts and contractors to ensure that corrections are made and new samples prepared. A sampling errors report is produced and made publically available which can be referred to in advance of the sampling phase of the next survey.

As well as checking sample data, we now gather metadata from trusts in the form of sample declarations. These forms requires trust staff and Caldicott Guardians to sign-off on each stage of the sample process. They also include information about the number of patients removed due to dissent. The forms were introduced to reduce the risk of trusts inadvertently sending identifiable data to the co-ordination centre, but the collection of the additional data on dissent has enabled us to identify a number of cases where trusts' information governance processes have compromised their samples.

Communication and support

Throughout the survey process, we offer expert support to NHS trusts and approved contractors on a daily basis via a number of channels. We operate:

- A dedicated **website** where we publish all survey documentation and results. This provides the information and supporting documentation that users need to implement the national surveys in a standardised manner.
- An 'advice centre' and survey specific email 'helplines'. E-mails to these addresses are automatically sent to all researchers working on a project to make sure that queries are dealt with quickly.
- A dedicated **telephone** 'advice' line where we respond to queries and advise trusts on elements of the survey process.
- **Approved contractor briefings** and **trust webinars**. These provide an opportunity to raise queries collectively and allows for clarifications to be given in advance of the survey process beginning.
- In advance of the 2014 Children's Survey, we also delivered **one to one consultation meetings** with NHS trusts that had never participated in the NPSP before to fully support them and prepare them for the survey.

This range of channels makes it easy for trusts and contractors to get information and support. In the future, we recommend further development of the website: whilst already a useful and well recognised element, it is relatively static and could be made more dynamic. One way for this would be in the submission of updated contact details for surveys leads at each participating trust, as well as contractor status, instead of emailing the co-ordination centre directly as is current practice. This has the potential to further streamline contacts to the co-ordination centre and reduce the time and cost of addressing queries.

Fieldwork monitoring

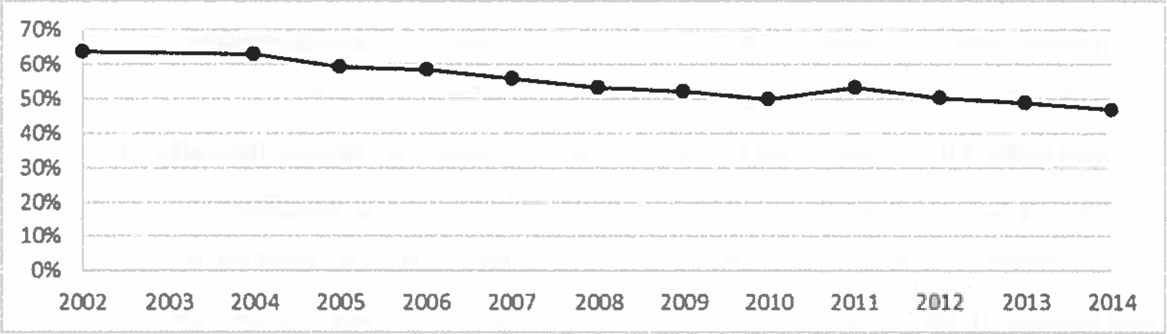
Devolved surveys rely on participating organisations to carry the administrative load of distributing questionnaires and collecting responses. They also bear the risk of error: for the co-ordination centre this limits capacity to risk-manage survey fieldwork.

To address this, we have developed and will continue to operate a **weekly monitoring** approach to gather intelligence on how fieldwork is progressing. We receive weekly updates from contractors and in house trusts, using a template that we make publically available, on the number of completed questionnaires, mailing date information and the current response rate. This information allows us to raise any concern we may have about the progress of a trust with either the contractor or directly with them. If appropriate, where we have significant concerns about whether a response rate will prohibit the quality and quantity of data for a trust, we escalate this to CQC and discuss the most appropriate course of action.

Increasing response rates: survey processes and questionnaire design

A key challenge for survey research is achieving and maintaining good **response rates**. Over the past 10 years there has been a steady, decline in response rates to national patient surveys, mirroring trends in market research more widely. This is illustrated in figure 2 below.

Figure 2: Response rates to the national inpatient survey over time



Low response rates can be the result of a complex interplay of personal, societal, and methodological factors. There are many theories about how individuals choose whether to respond to surveys – but the most widely accepted general theory is the "leverage-salience theory" (Groves, Singer, & Corning, 2000). This posits that the decision to respond corresponds to the sum product of the leverage and salience of survey characteristics (such as topic, sponsorship, and incentives) to the individual.

One consequence of leverage-salience theory is that different design features may produce different 'leverage' effects for different recipients. This is important because it implies that designing interventions to appeal to underrepresented groups may improve survey representativeness rather than just response rates – and improving response rates can, in some cases, actually *decrease* representativeness (eg Groves & Peytcheva, 2008). In the future, it might be prudent to consider targeting costly interventions at specific groups where they have the greatest benefit. This is discussed further in our response to case study 8, attached.

Broadly speaking, the existing NPSP benefits from a best-practice approach that includes the majority of design features associated with good response rates. This corresponds to the tailored design method (Don A. Dillman, Smyth, & Christian, 2014) and includes a maximum of three mailings sent to sample members. Similarly, the surveys include many of the factors most closely associated with improved response rates in a comprehensive Cochrane review of postal & electronic survey response rates (Edwards et al., 2009). As such, it may be hard to identify single interventions that lead to substantial improvements in response rates without unmanageable cost implications – but in this section we describe a range of smaller, cost-sensitive interventions that could be explored to improve overall survey response and representativeness following a marginal gains approach.

Improving the design of survey materials

Survey covering letters (and reminders) are addressed to the respondent and designed to explain the purpose of the survey and address confidentiality concerns. This is a 'one size fits all' method with the same covering letter being sent to all sampled patients. In future we suggest experimenting with **different mailing content** tailored to different sub groups within the patient group. This could include increased personalisation, age-appropriate language and socio normative messaging (eg information in reminders about how many other people have already responded). Learning from research on behavioural insights elsewhere in the public sector, we could highlight key messages around the value of the survey and actions required of respondents (Cabinet Office, 2012). To date, we have trialled allowing trusts to add text to covering letters to include some feedback of how they have used the most recent survey data to make improvements. Whilst this was introduced for the 2014 A&E Survey, it was done on a voluntary basis the impact of this intervention on response rates is thus unclear. There may be merit to testing this within the constraints of a scientific experimental design to fully understand whether an effect is present.

The **appearance of the questionnaire** is another consideration. Questionnaires in the NPSP have followed a consistent design and format since 2002. This design has generally proven acceptable but its rather conservative appearance may not best appeal to all potential respondents. The design and layout could therefore be reviewed to see whether a redesign could influence response rates. We are in the process of implementing a pilot trialling a re-designed questionnaire on the 2015 Inpatients Survey. The re-designed questionnaire uses more colour (to enable respondents to better differentiate between section headings and response option boxes), visually clearer routing instructions, and larger and clearer font size.

Questionnaire length also affects response rates and there is a balance to be struck between sufficient breadth of coverage in the questionnaire and ensuring that it is not so long as to deter respondents. Evidence from a Cochrane review shows that shorter questionnaires are one of the most effective interventions for improving postal survey response rates (Edwards et al., 2009). A radical, but potentially important, consideration for the national programme would be to look at producing a short form for each survey. This would include the top 15-20 priority questions that CQC requires for their regulatory purposes and any areas that the co-ordination centre has identified as key measures of a better experience. A **short form** could be used in place of the standard replacement questionnaire sent in the third mailing, and this could be specifically targeted at harder to reach groups (including younger people and those from BME groups). This is a prime example of how a tailored approach could make balanced compromises to try to get at least partial data from groups who are currently underrepresented in the survey, and we would strongly recommend trialling this via a pilot study in 2016.

Improving survey publicity

A pilot designed and undertaken by the co-ordination centre in early 2014 identified that the programme may benefit from **increased communication around the survey** in advance of fieldwork and, potentially, in advance of the sampling period in a bid to increase response rates. The co-ordination centre currently produces templates for publicising the survey and advise trusts to use their communications teams, local and social media channels to engage with their own patient population about the survey. However, there are currently no measures in place to determine uptake of these methods, how the different methods are used or the effect on response rates. A possible pilot could investigate the effect of different publication methods and their timings on response rate, to identify whether a clearer communications strategy around should be developed and implemented. In addition, it would be ideal to undertake exploratory qualitative work with communication teams at CQC and different trusts to identify ways in which the publicity materials could be re-designed to be more engaging, dynamic and fit for purpose.

Incentives

Financial incentives are a proven and effective method of improving response (eg Edwards et al., 2009), and are used in a number of longitudinal and birth cohort studies such as *Understanding Society* (The Economic and Social Research Council, n.d.). Potentially, this could be trialled in the NPSP: although unconditional incentives in the first mailing would likely be cost prohibitive, a 'lottery' style approach featuring a prize draw for respondents could be manageable. However, any approach involving financial incentives would risk creating adverse publicity, particularly at a time of intense pressure on NHS finances: for that reason, we would not recommend pursuing incentives in the near future.

Survey mode

Response rates are also closely linked to the survey mode used for gathering feedback. The vast majority of the surveys within the national programme use a postal paper self-completion questionnaire mailed directly to patients' home addresses. This allows a large volume of data to be gathered in a standardised and cost effective way, and ensures broad coverage of patients from all age groups. Postal surveys will likely remain the optimal approach for at least the next five years. However, other modes of collecting data should not be discounted for future surveys, and may be trialled as part of innovations to the programme.

A key characteristic of postal surveys – and one important to making them cost-effective – is that they are self-completed by respondents. **Interviewer administered methods** – including computer assisted telephone interviews (CATI) or face to face computer assisted personal interviewing (CAPI) are an alternative. These methods have a number of benefits: historically they achieve higher response rates than postal surveys, better data quality, and allow more complex routing, sampling, and nonresponse analysis to be employed.

The NPSP has recently used CATI for the 2013 Hear and Treat Service Users Survey. We developed a survey instrument to collect feedback on people's experiences of calling 999 and being treated over the phone: unlike other surveys in the NPSP, this was centrally managed by the co-ordination centre and undertaken by a sub-contractor. This method worked well due to the sampling frame: the contact the service user had with the ambulance service was by phone.

Whilst interviewer administered methods have advantages, the main disadvantages centre on costs. Fieldwork costs for interviewer administered surveys are high owing to having to train and pay for field interviewers. Unlike in postal surveys, there is little economy of scale to be exploited with larger sample sizes: interviewer time is required for every interview, making unit costs extremely high: in the order of twenty to fifty times the cost of response in a postal survey. For the vast majority of surveys in the NPSP, interviewer administer methods must be ruled out as cost-prohibitive.

Online surveys are arguably the most similar alternative to postal questionnaires. They similarly focus on self-completion and rely on closed questions presented in a relatively predictable format; mode differences between paper and online surveys tend to be small. Attractively, online response has potential cost benefits as it removes the cost of data entry and postage. But significant barriers remain as to the viability of online response in NHS patient surveys – not least because of limited online access amongst some key demographic groups (eg older people) and the fact that most NHS organisations do not routinely collect email addresses.

A number of previous studies have been conducted investigating the impact of mixed-mode method survey designs with particular focus on the potential for cost-effectiveness and reducing non-response and population coverage errors (De Leeuw, 2005). Research suggests that offering mixed modes sequentially, in what is referred to as a 'mode crossover' approach, tends to increase response rate (Dillman, Smyth, & Christian, 2009). However, recent research has shown that offering postal and online data collection modes concurrently actually has a detrimental effect on overall response rate (Medway & Fulton, 2012).

To investigate the feasibility and impact of adding an online response option, we undertook a pilot on the 2012 Accident and Emergency Survey which offered an online mode to all sampled patients. Because NHS trusts do not routinely collect patient email addresses, first contact about the online survey was introduced to the patient via the covering letter accompanying the paper questionnaire – meaning this was a pilot about mode of *response* rather than mode of *contact*. The pilot found that only 7% of respondents completed the survey online, and overall response rates were not improved by the addition of an online option. A similar pilot implemented on the 2013 Inpatients Survey achieved similar results. In this pilot, we investigated the use of a pre-approach letter versus a pre-approach and reminder mailing promoting the online method in advance of a paper questionnaire being sent. Whilst response to the use of a pre-approach letter was effective in encouraging more people to respond online, overall response rates were not increased and there was a deleterious effect on survey cost.

Despite these discouraging findings, it would be prudent to continue to review online surveys as a potential mode for particular sub-groups within a patient population. Comparability analysis of the responding profiles (paper vs online), for the 2012 A&E pilot, suggested that those completing the online element were more likely to be younger and male. Building on these findings, the national programme may benefit from future pilots looking at targeting particular sub-groups, such as younger people, and allowing them to complete the survey online. This would be relatively straight forward to implement: using the sample information, trusts could identify which patients fall into the age group of interest and insert a flag into the sample file. This method may be most effective if eligible patients could be contacted via email, permitting a sequential contact methodology involving emails first and then postal follow-ups for nonrespondents, which means that improvements in NHS data recording may be a prerequisite. Where email addresses continue to be unavailable, we could investigate the use of targeted mailings with a QR code printed on them, that when scanned would take the respondent directly to the online survey: this may provide a simpler mechanism for helping people to access an online survey, although we are cautious about the likely benefit of such an approach (not least because the most commonly used mobile operating system – Apple's iOS – continues not to offer built-in support for QR codes).

Analysis and reporting

The 'final' stage in the survey cycle is analysis and reporting. The NPSP produces outputs for a number of different purposes and users. As a result, there are a number of different data products aimed at different audiences.

For comparative purposes, results are benchmarked by converting responses into scores. The current benchmarking approach is designed to detect exceptional results, compared to the majority of scores that are 'within [statistical] control' (Spiegelhalter et al., 2012). Responses to evaluative questions are converted into scores on a 0-10 scale. Case weights are created to standardise trust-level data to a common respondent profile. The survey results are generally amenable to random-effects variance components modelling, with both between-trust and within-trust variance applicable. Trust performance is then positioned in relation to the distribution of scores for 'within control' trusts, this being derived from their deviation scores (z-scores) and correcting for over dispersion using Winsorization. This results in an 'expected range' of scores, specific to each question and each trust, that combines between-trust and within-trust variance and enables 'out of control' scores to be identified. We have developed control syntax to implement all stages of these analyses, including for composite scores representing questionnaire sections, where the computation of within trust variance is less straightforward. To report on change from the previous survey, historic scores are reported and t-tests applied to identify statistically significant changes.

The current benchmarking approach has some limitations. The 0-10 scoring approach has been developed to summarise questions with several response categories, but may confuse some users. A conceptually simpler alternative that could be piloted is a 'top-box' scoring approach where the proportion selecting the most positive evaluative response to a question is used to summarise trust performance. While this approach loses some detail for questions that have multiple response options, we have found it to provide similar levels of between-trust discrimination to the 0-10 scoring model (Sizmur, 2012). The current 'expected range' approach could be applied, or alternatives explored.

Case-weighting of survey data can run into practical difficulties when there is large inter-trust variation in sample composition (eg trusts with no emergency department, or with atypical demographic distributions). Capping weights at a specified maximum (as currently done) reduces the effectiveness of the standardisation. The method cannot be extended to include additional weighting variables, and three variables is a practical limit. We have shown that regression adjustment methods are feasible with national survey data and hold promise in overcoming these limitations (Raleigh, Sizmur, Tian, & Thompson, 2015). Consequently, we have a developed methodology that we have already piloted and that could be applied to the NPSP. We would recommend considering the adoption of this in future surveys.

Whilst computation of the expected range of in-control trust scores is generally unproblematic, there are circumstances where data conditions threaten the suitability of the approach. Accurate estimation of between-trust variance is dependent on an adequate sample of trusts, but there are surveys (such as for the ambulance service) where the number of trusts is very small. There are also occasional survey questions where one or more trusts achieve a 'perfect' score of 10 (or, conversely, 0) and these questions then have zero variance within the affected trusts. When there is a large number of such trusts, estimation of between-trust variance can be biased. From a practical viewpoint, the concept of expected range is difficult to explain to data users and results in most trusts being 'about the same' on most questions. This is a result of the robust but conservative rationale for the approach (the identification of outliers for risk screening purposes). It would be useful to review the usefulness of this approach to stakeholders and potentially replace it, or supplement it, with more discriminating data in benchmark reporting. For example, trusts could additionally be presented with percentile ranking of their scores. While these have limited reliability, their display (with caveats) may be of value to some audiences.

The use of 'null-hypothesis significance-testing' in investigating changes in trust scores over time may be adequate for present purposes, but the approach has critics (Cohen, 1994) and there may be more informative ways to display historic data. We have applied statistical control chart methodology to time-series data in the Inpatient Survey; this method puts any possible underlying change in the context of the 'natural' variation in scores and could be explored further in future.

For trusts, the benchmark data is produced in the form of a PDF report with charts showing the expected range of scores for each question and where the trust falls in that range. Whilst changes have been made to the benchmark reports in recent years, they are regarded as being relatively 'flat' reports. One innovation that could be made to the reporting of the benchmark data links with the approach described in our response to Case Study 7: instead of producing a static report, data could be hosted in a digital format allowing trusts to engage with the data to a greater extent. This may increase the usability of the data by trusts and allow them to focus their improvement initiatives more effectively.

Trusts also receive unweighted percentage results for each question within the survey, where they have a sufficient number of responses for the data to be displayed. These results are presented in Word format to discourage inappropriate manipulation. The data is unpublished and is used to highlight how different proportions of patients responded to each of the questions. We could look at presenting the data in a different format: we would recommend consulting with trusts to determine the format most useful for them. One potential option would be to produce the data in Excel, as demonstrated on the 2014 Children's Survey, where tables for each survey version were arranged on the same worksheet to enable trusts to look across results for comparable questions. A more dynamic option may be to produce a design template, such as an infographic, that trusts could adapt to enter some key findings and use in publication of their survey results.

National level data is also produced for each survey, which is used as the basis for CQC's enhanced summary. The data is analysed to make comparisons to the previous survey year and weighted to account for the number of respondents per trust. This means that each trust has an equal impact on the data, regardless of their size or response rate. This output is published on the CQC website and trusts are made aware of the findings. We do not envisage changing the format, design or analysis techniques for this report.

One relatively untapped source of data is the free text comments collected in each of the surveys. Whilst there have been exercises around thematically coding this data for some surveys, such as inpatients and maternity, this has not been done consistently. It may be beneficial to trusts to receive a summary of themes from their free text comments: this could be provided back to trusts either in an Excel workbook, with guidance about the coding, or incorporated into the benchmark reports. We have recently implemented the latter approach for a large-scale neonatal survey run by the Picker Institute: the systems to incorporate the free text comments have already been established so there would be minimal set up costs incurred if we were to pursue this for the NPSP. Drawings were also collected on the 2014 Children's Survey: guidance was produced by the co-ordination centre about how to use this data, and analysis of these images is currently in progress.

Finally, we also recognise that CQC has responsibilities around the safeguarding of children and vulnerable adults. We have our own safeguarding policy and all of our staff are trained on safeguarding; moreover, we have developed a simple approach to highlighting to CQC patient survey comments that potentially raise safeguarding issues. In future this could be included as a standard part of surveys and other feedback mechanisms.

Summary

We see surveys in the NPSP as following a continuous cycle of development and improvement (see figure 1, above). This cycle incorporates four sequential phases – development, fieldwork, analysis, and review – and focuses on securing quality and building improvements. We have described the content of each stage and the various activities undertaken within them – from sampling and questionnaire design, to survey co-ordination and oversight, to data analysis, and finally improvement. .

In this section, we have highlighted possible improvements to practice, including:

- Investigating the feasibility of larger or more statistically efficient sampling methods to extend the value of data from existing surveys.
- Creating new tools to support trusts in sampling.
- Trialling the use of short-form measures to provide partial survey data for current non-respondents and improve representativeness.

A further possibility is to review the timing of surveys within the year to more effectively structure the programme and build efficiencies in delivery for CQC, the co-ordination, and trusts. As a programme level issue, this is beyond the scope of this response – but we would welcome further discussion with CQC.

Delivery and Development of Feedback

In this section we set out our approach to the delivery, development and substantive review of feedback mechanisms to collect the views of those who use, or are employed by providers of, adult social care services that CQC inspect.

In March 2015, CQC released a set of handbooks detailing its approach to the regulation, inspection and rating of services from April 2015. These handbooks outline how it will regulate hospice services in adult social care, community adult social care services, and residential adult social care services (Care Quality Commission, 2015b, 2015c, 2015d). These show how feedback from users, family and carers, and staff from adult social care services is a key source of evidence that contributes to helping plan inspections. We understand the importance of using feedback to monitor and inform improvements, as shown in our proven track record of working with regulators and NHS providers.

We have more experience than any other UK organisation of designing, implementing and analysing patient and staff feedback collections. We have also demonstrated our ability to successfully take over the co-ordination of large-scale projects previously run by other organisations namely the National NHS

Staff Survey (previously managed by Aston University) and the Community Mental Health Survey (previously managed by NatCen). We not only ensured the smooth transition of these programmes of work but also have delivered improvements since doing so.

As described in 5.3.2 below, our team have research experience in the field of social care. In collaboration with the King's Fund we worked on a study exploring the feasibility of a national survey of adult social care for CQC. Chris Graham and colleagues from the Picker Institute are in discussions with the National Clinical Director for End of Life Care (Dr Bee Wee), and other NHS England representatives, to explore the potential of conducting further research into the experiences of people approaching the end of their life, to supplement the VOICES survey which gains feedback from carers. In addition to this a member of our team, Carolina Casañas I Comabella, is in the last few months of completing a PhD (under the supervision of Dr Bee Wee) exploring the needs and experiences of distance caregivers in palliative care. This demonstrates our enthusiasm to study and shape future adult social care collections, which will benefit CQC as it will lead to an increased sharing of knowledge and communication around the measurement of adult social care.

We understand the importance of making sure that any feedback used in the inspection process is fit-for purpose. Here we demonstrate how we will support CQC in collecting the right feedback to strengthen the new regulation process.

Delivery of a feedback mechanism

Obtaining information about people's experiences of social care services (community based care, Shared Lives Schemes, residential care, inpatient/day case and community hospice care) requires a different approach to that used in the NPSP.

The provider landscape is different; it is not just NHS providers but local authorities, independent providers (from big corporate companies to small agencies) and voluntary sector services. The differences between providers and the types of services provided may require the development of different methods of data collection. For example, whilst it may be feasible to use volunteers to collect real-time data from people receiving inpatient care (in a residential home or hospice), this is likely to be impractical and too costly for those receiving community based care.

Gathering feedback from staff on their experiences can also present different challenges compared to surveying service users. The knowledge we have about employee surveys and our work to improve the

NHS Staff Survey (eg via the addition of an online mode of completion: see 5.2.5 below) provides us with the skillset to carry out and build on the surveying of community professionals and provider staff.

There is also greater diversity of individual user needs present in those who access adult social care. Two thirds of those receiving care through local authorities are aged 65 or over and, in addition, more adults are living with multiple conditions (such as a physical or sensory disability) making needs more complex and difficult to meet (National Audit Office, 2014). Being aware of these characteristics is important when designing a collection of feedback mechanisms.

We also understand that the mechanisms for gathering feedback from those who use or provide adult social care services are not designed to provide comparable data across all providers in a sector (CQC ITT, p3). Whilst the roll-out of feedback mechanisms to obtain feedback from adult social care services for the purposes of inspection will involve different activities and considerations to the NPSP (because of the factors noted above), there are similarities and learning which can be shared between programmes: and we refer back to section 2 where our approach to tasks for both programmes of work would follow the same procedure and best practice.

This section outlines our approach to the quarterly collection, analysis and reporting on feedback for community based care, Shared Lives Schemes, residential care and hospice care provided in both people's own homes and in hospices.

Project hand-over

In the first six months, we will carry out the established collections using the current processes being implemented by CQC. This will ensure continuous service for CQC and will allow the co-ordination centre time to a) plan and carry out a thorough review of existing processes and b) develop new mechanisms for the collection of feedback on people's experiences of hospice care (provided in hospices) and residential care.

To ensure a smooth transition, an initial hand-over meeting with CQC (and previous supplier if applicable) is recommended. In this meeting we would look to clarify CQC's requirements and desires for the future of the collections. We would also ensure that CQC are happy with our suggested approach to project and relationship management – see section 4 below, for more details of these.

We will also request the transfer of key documents, where possible, for each of the data collections to ensure that we get a full understanding of how each collection has developed over time. Documents requested will include development and evaluation reports, questionnaires, analysis plans, guidance materials and provider details.

Communication with providers

Effective communication with providers is important; we want to make the process as easy as possible for them whilst also making sure that timetables are adhered to and feedback is collected on schedule. The set-up of a database of eligible providers and the use of a guidance manual will aid this communication.

Database of eligible providers

As part of the hand-over we will request access to any existing database(s) containing provider contact details. If this does not exist then we will create a new database based on the information CQC acquires through registration. This is important for the ongoing communication of information regarding data collections. Information will include the type of services provided and number of locations per provider. This database will be updated throughout the year to take into account changes in staff at the provider sites and the number/types of eligible services: for example the number of Shared Lives Schemes is likely to continually increase (Shared Lives Plus, 2015).

Guidance materials

We will produce guidance materials to support providers with the data collection process. In the short term, guidance materials will be based on the existing approach used by CQC for gathering feedback prior to an inspection. If guidance materials already exist these will be utilised and updated as required. Basing guidance on the current approach will help to ensure the effective hand-over of this work and will allow time for us to review the methodology. A comprehensive review and update of materials will take place as part of any substantive review or ongoing development.

We recognise the importance of ensuring that guidance materials are clearly understood and adhered to by providers so that a consistent approach is taken when administering collections; this is imperative for the data to be sufficiently robust for inspectors to draw conclusions about the reported experiences of care. We have considerable experience in writing guidance for staff in a range of roles within many different care settings, both for the NPSP and other collections. To help us to identify any areas of the guidance that require improvement we recommend undertaking a verification process by carrying out follow-up calls with at least 10% of providers. We would check that samples were drawn correctly and, for the providers of residential and hospice care provided in hospices, check that questionnaires were administered as intended.

Co-ordination centre website

We will develop separate webpages on the co-ordination centre website (http://nhssurveys.org/) for this package of work where providers can download the guidance and supporting tools. An additional domain name, to be agreed with CQC, will be purchased: this will avoid the use of 'NHS' in the name but will redirect to our existing page to avoid unnecessary development costs.

Provision of an advice line and email address

The co-ordination centre's telephone advice line will be made available for providers wishing to contact us for support or who have queries about the fieldwork process. We will create an email address, specific to the delivery of these feedback mechanisms, which will be sent to the researchers working on these data collections. This approach to handling queries has been used by the co-ordination centre for a number of years & enables us to deal with queries effectively and in a timely manner.

Delivery

We understand that the collections to be implemented within the remit of this contract are quarterly collection, analysis & reporting of feedback for:

- community based care;
- shared lives;
- hospice care provided in people's own homes;
- residential care (new collection to be introduced); and
- hospice care provided in hospices (new collection to be introduced).

Our proposed approach is to administer these collections centrally as this will allow us to implement and manage a consistent approach across collections (including ensuring user and staff samples are checked and that questionnaires are mailed out at the same time); minimise the chance of error; and reduce the burden on providers. Moreover, it is hoped that response rates would be higher and users would feel more able to provide honest feedback when returning their questionnaires to an independent third party. The Hospice Patient Survey (Jenkins & Codling, 2013) uses this approach whereby questionnaires are returned to the Centre of Health Services Studies, based at the University of Kent, for analysis and reporting.

For the collection of feedback for community-based care, shared lives schemes and home-based hospice care, central administration will require transfer of user identifiable data. We will seek support under section 251 of the Health and Social Care Act allowing the sharing of user name and address details for the purpose of administering the feedback collections. As described in 5.2.6, we are experienced with dealing with the process of applying for and securing section 251 approvals.

A suitable model will be implemented to ensure safe and proper handling of user identifiable data. This follows the good practice set out in Rule 5 of HSCIC's 'Guide to confidentiality in health and social care' (Health & Social Care Information Centre, 2013). Our information governance arrangements are described further in 4.5 below.

Collection

For the successful hand-over and delivery of existing collections, we will develop processes for:

- Providing providers with guidance materials including sampling instructions.
- Receipt and checking of samples (user name and addresses and staff names & email addresses) from providers. Samples will be sent to the co-ordination centre for checking and in preparation for fieldwork. For patient confidentiality reasons, providers will be asked to send two files: a 'mailing file' which just contains users' names and addresses (and staff names and email addresses) and a 'sample file' which contains other information about the user or survey (eg year of birth, ethnic group, provider name). Keeping the two sets of information separate reduces the information disclosed if either file were to be lost or shared with unauthorized individuals. For maximum security and confidentiality we will instruct the provider to password-protect and encrypt (256-Bit AES) the files and send to the co-ordination centre over our secure file transfer protocol (SFTP). Each sample will be checked by a member of the co-ordination centre.
- Printing, packing and postage of questionnaire packs; including use of unique ID numbers allowing us to link returned questionnaires with providers.
- The set-up and hosting of online questionnaires for staff and carers/family/friends. Information will be included in the covering letters sent to users about how their carer/family/friend can complete a survey online. This will include a QR code that, when scanned, would take the person directly to the online survey. Provider staff will be sent an email with a direct link to the survey.
- Management of online questionnaire distribution (emails to staff) in-house using Snap Webhost (professional survey software designed for this task). We will use a secure server for all

collections, logging responses the instant they are received. An email account allowing people to opt out will be linked to the online collections and will be monitored at all times.

- Recording response rates; this will allow us to monitor the fieldwork and follow-up with any providers where there is, for example, a lower than expected number of returns for the online staff survey.
- Capturing response data and validating the data entry. All paper-based questionnaires will be logged on arrival. The barcode from each questionnaire is double entered as a quality check. Confidentiality will be maintained by keeping the mailing and response files separate. For all data entry tasks, data capture instructions, data structure and data logic documents will be generated including rules on the data entry of freetext comments.
- Management of a freephone helpline for participating users, family members and staff to call if they have any queries. A dedicated freephone number will be created for this programme of work. Freephone calls relevant to the mailing process (eg opt outs, ineligibles) will be logged daily. We have freephone guidelines in place to ensure that freephone handlers first ask callers for the unique ID number on their questionnaire, not their name/address details. Only when the caller is unable to locate the ID will the handler ask if they can take name/address details, and whether the caller minds that this information is passed on to the co-ordination centre.

We will consider the use of a subcontractor for undertaking these tasks to increase efficiency. We have the knowledge and experience of using sub-contractors for delivering these services for other large-scale projects collecting feedback from users (eg the 2014 voluntary Neonatal Survey). Any subcontracting will be undertaken only with organisations with which we have a well-established working relationship and who operate in accordance with our security standard ISO 20252. As part of our ISO 20252 accreditation, all subcontractors are required to abide by the same quality standards in any work they undertake on our behalf. We accept full responsibility for overall completion of projects undertaken with sub-contractors.

Data analysis and reporting

We will request copies of any data analysis plans as part of the hand-over of these collections. Using these plans as a guide, we will undertake the data cleaning (for example we will ensure a minimum of 5% of all returned questionnaires, selected randomly, are checked against the original questionnaires) and analysis of data using detailed syntax created in SPSS. Using syntax ensures that we have a log of all actions taken in the cleaning of the data and that we can readily duplicate any actions taken. A thematic analysis approach will be used to identify, analyse and report (themes) within qualitative data. A key part of this will involve the identification of comments that potentially indicate safeguarding issues with coding categories informed by CQCs safeguarding policy (Care Quality Commission, 2015e).

The presentation of this data will be agreed with CQC; for example it could be provided in an excel workbook, with accompanying guidance about the coding undertaken, or incorporated into reports containing quantitative data.

Appropriate reporting outputs will be developed to ensure the results are useful both for CQC inspectors and for providers to drive location-level quality improvement.

Development of feedback mechanisms

We understand that a suitable methodology and questionnaires will need to be developed for gathering user, carer/family and staff feedback of residential care and care in a hospice. These and the current collections will be subject to on-going development informed from a review conducted before each cycle. The approach we will take to the development and review of these collections will include:

Desk research

Desk research could include evidence scans or a comprehensive literature review and would help inform decisions on the future of the programme of work. As a minimum we would expect to carry out desk research looking at what evidence needs to be collected (to inform questionnaire content) and the ways this evidence could be collected (sampling and methods).

Questionnaires

Ideally, questionnaires used for collections should provide data that not only informs the CQC inspections but enables providers to use findings to drive service improvement. When developing new questionnaires it will be important to review existing tools to determine how they are rolled out and if they contain existing questions appropriate for inclusion in this programme of work. It will also help in judging if there is a risk for some users of services to be over-surveyed which may have a negative impact on response rates. For example, people in residential care homes may already receive the ‘Your Care Rating’ survey (Ipsos Mori, 2015), the Marie Curie Cancer Survey (Marie Curie Cancer Care, 2013), and any other questionnaires being implemented locally. A review would consider:

- What tools already exist?
- How are they administered/implemented?
- Is there evidence of their measurement characteristics (validity and reliability)
- What evidence is there of their perceived effectiveness and applicability (eg do they lead to improvements is people's experiences?)

Sampling

We would review the existing sampling methods used to gather feedback on people's experiences of community based care, shared lives and community-based hospice care. An important part of this review will be the consideration of sample sizes for different providers/services. We know from previous work that the numbers of users receiving social care services can vary enormously, not only between the types of service (eg community-based care or residential care), but also between providers. Whilst some providers deliver care to fewer than 10 people, others provide care to over 500 people. Therefore, it is likely that a different sampling approach will be required for different providers: for example smaller providers could take a census of their users whilst larger providers could take a random or systematic sample to manage administration costs. Consideration would need to be given to excluding people from the sample for capacity reasons. Under the Mental Capacity Act 2005, people who are unable to give their consent to take part should not be included as respondents in a survey; both the Personal Social Services Adult Social Care Survey (Health and Social Care Information Centre, 2012) and Your Care Rating survey (Ipsos Mori, 2015) have introduced steps to filter out ineligible people based on their capacity to consent. As the responsibility for assessing the capacity of service users to provide informed consent rests with care managers, the criteria for excluding users would need to be clearly outlined in our sampling instructions for providers.

Methods of collecting data

In a desk review of methods for collecting feedback we would consider the issues, benefits, costs and risks associated with each. From our past work reviewing the feasibility of an adult social care survey we have a good understanding of existing and past methods of administering social care surveys including their accompanying costs and benefits. For example, we know that CQC, recognising the challenge of surveying people receiving care in their own home, used a mixed-method approach to gather user experience data in their home care inspection programme 'Not Just a Number' (Care Quality Commission, 2013). In addition to a paper-based survey, an alternative web-based form was developed and telephone interviews and home visits were carried out. The Hospice Patient Survey (Jenkins & Codling, 2013) and a project looking at real-time reporting of the experience of users receiving care in the last year of their (NHS Improving Quality, Marie Curie Cancer Care, & Hospice UK, 2014) will also be useful in reviewing developments.

Our knowledge of the main strengths and weaknesses of the more common approaches for carrying out data collections will prove valuable when thinking about changes to the delivery of any of the feedback mechanisms. For example, a postal survey can collect high volumes of data at an acceptable cost across services which are geographically dispersed. However, face to face interviews could bring better response rates from users who have physical and/or cognitive impairment who may not find a postal survey accessible.

User and stakeholder involvement

There are many benefits to the involvement of users and stakeholders in this work, from helping shape content to ensuring that the language & information focussed on in questionnaires are appropriate and accessible. Involvement will be achieved via

- Stakeholder consultation (including CQC key personnel, steering group and CQC inspectors) to determine current policy, regulation and improvement needs.
- Consultation with providers to understand current practices and how information on users and staff is recorded. Consultation will also allow us to evaluate the performance of guidance materials.
- Consultation with national and local organisations and community groups representing people who use social care services to understand the issues involved in gathering feedback from this group users (eg Healthwatch, Shared Lives Plus, Age UK, National Association for Hospice at Home, Hospice UK, National Council for Palliative Care).
- Focus groups or depth interviews to explore what is important to users, family members/friends/carers, and staff.
- Cognitive interviews with users, family members/friends/carers and staff.

Evaluation

Findings from any review would be analysed and evaluated, culminating in a detailed report including options on how a new collection could be carried out or how improvements to existing collections could be made. Options considered would need to fulfil the following criteria:

- Facilitates the effective collection of evidence needed to assess services performance against CQC's key lines of enquiry (KLOE).
- Enables the views from a wide range of people, including those with cognitive impairment, to be included.
- Sufficiently robust to ensure confidence in the findings and allow performance, at provider-level, to be monitored over time.
- Would drive quality improvement work by providers.
- Would be practical to implement, minimising both the burden on providers and the risk of errors being made (in sample selection or administration).

Pilot

Changes to key feedback collections need to be considered carefully; innovation, whilst important, should not be made at the expense of data quality. With the introduction of a new collection (such as gathering feedback from those who use services in a hospice setting) or a substantive review resulting in proposals for change to an existing collection (such as to the sampling frame or mode of delivery) it would be prudent to carry out a pilot. Here we list examples of specific pilots that could be considered as part of the process of developing feedback mechanisms:

- Pilot testing the option for users to complete their questionnaire online through the use of a scannable QR code.
- Piloting of questionnaires that can be completed by children and young people receiving hospice care at home. Our understanding is that currently parents answer on behalf of their child. However, the 2014 NHS National Children's Inpatient and Day Case Survey has demonstrated that children from the age of eight can complete questionnaires and provide feedback on their experiences.
- If, after reviewing collections, we find low response rates from carers/family/friends then we would consider alternative approaches to the use of an online questionnaire. This could involve a pilot testing the introduction of sending out two paper questionnaires to each user: one for them and one for them to pass to their carer/family/friends. Or indeed, if we find that providers keep accurate up-to-date records of carer/family addresses then we would look to pilot the sending of a paper-based questionnaire out directly to the home address of the carer/family. Obtaining feedback from carers/family/friends is important for broadening the scope of service user experience feedback as many social care users' will lack the ability to express their views.

- Use of CQC's Experts by Experience (with the support of volunteers) to administer surveys in hospices and residential care via electronic devices at the point of care. There is some evidence that this method of survey delivery, using hand-held electronic tablets, is acceptable for collecting the views of patients approaching the end of life and that there is considerable value in using volunteers to support the process (NHS Improving Quality et al., 2014). We can draw on the knowledge and experience of a team of researchers at the Picker Institute who work with a number of trusts to collect real-time feedback from users (see 5.3.1). We recognise the important role that volunteers can play in collecting this feedback. In a research project we are currently carrying out with the University of Oxford, we have experience in training volunteers in using tablets to gather data on people's experiences of care (Picker Institute Europe, 2015).
- As mentioned in case study 5, a pilot may be required to help test new ways of presenting results, including qualitative evidence, for inspectors and providers.

Summary

In this section we have outlined our approach to delivering and shaping the future social care collections describing first how we will ensure the smooth transition of existing collections and then how these will be substantially reviewed. We have also outlined how will develop the mechanisms for collecting feedback on people's experiences of residential care and hospice care provided in hospices.

Understanding the importance these collections play in the inspection process and how they can be used to drive quality care we have suggested possible improvements to delivery, which includes:

- Administration of data collections centrally, on behalf of the providers
- The use of pilots to introduce new innovations such as obtaining feedback directly from children and young people.

Relationship management

As outlined in our strategic vision (see 1 above), we will work in close partnership with CQC to ensure that the Commission's needs are understood and that work undertaken contributes to the advancement of its objectives. This partnership will be supported by a comprehensive relationship management approach that will both ensure that day-to-day interactions are effective and productive and that projects progress to plan.

Overall, we can sum up our relationship management approach as follows. This not only describes our current approach as the co-ordination centre, but also the basis on which we will work in the future: and changes set out in this proposal should advance our relationship in these directions.

- Customer focussed: we are committed to understanding CQC's needs and developing, in partnership with you, innovative solutions to address these.

- Collaborative: not only do we value our partnership with CQC, but we value the expertise and insight of the CQC team. We know from experience that our surveys are most successful when the co-ordination centre and CQC are able to work together to make decisions – so regular information sharing and discussion of options is an important part of how we will collaborate.

- Transparent: openness is a feature of how we work with CQC as partners. We will make materials & thinking available early & often, and will produce metadata about co-ordination centre practice and performance to share with CQC.

- Accountable: we are committed to holding ourselves accountable to a promise of effective, reliable delivery. That means robust project management, with clear deadlines & line of sight for CQC as a commissioner: as set out in 1 above, we will create confidence in the co-ordination centre as a dependable service.

In this section of our proposal, we describe how we will work with CQC and project manage co-ordination activities. We also describe our quality assurance and risk management processes, as well as our approach to information governance and data protection. And, as we recognise that CQC need to be able to interact effectively with a broad range of stakeholders, we also describe how the co-ordination centre will support CQC in the establishment and management of project steering groups, as well as engaging with wider networks of stakeholders.

Working with CQC

We will work in close partnership with CQC to deliver the co-ordination centre's various work packages. Effective partnership means high quality, reliable communication – and we are committed to ensuring that CQC receive regular information on all aspects of projects, as well as having the opportunity to discuss work with the co-ordination centre as required.

Communication between CQC and the Co-ordination centre

Routine information sharing will be undertaken via a series of planned, regular activities, including both written updates and scheduled conversations. These planned communication activities will include:

- Weekly operational delivery meetings will be held, as required in CQC's specification (section 11, p.21). These will usually be attended by the programme lead (see 4.1.3 below) with other members of the co-ordination centre team as required. These meetings, which will take the form of a short operational update, will allow a review of current progress and operational priorities, as well as analysis and management of risks and progress. Alternatively, the co-ordination centre already holds operational briefings on Monday mornings; we would be pleased to extend invitation to these meetings to the CQC team to ensure better partnership working and transparency.

- Fortnightly written project updates to be delivered to the CQC team on alternate Fridays. The updates will, as a default, follow the established pattern of content currently used in co-ordination centre fortnightly updates. The main updates section will consist of a table with separate rows for each active project. Separate columns will describe work completed for each project within the previous two weeks; plans and priorities for the forthcoming fortnight; and an indication of who is responsible for upcoming actions. In the future, we will also add a new 'status' column to indicate whether projects are running to timetable – and, if there are any delays, what action is being taken in response.

- Monthly written programme updates covering costs on all projects, updating a programme-wide risk management matrix, & reporting performance against agreed KPIs. These will be shared at an agreed point each month and scheduled to precede monthly management meetings (see below). They will also include progress against project timetables, noting any delays and outlining actions being undertaken or proposed in response: full project timetables showing progress in Gantt chart format will be supplied as supplementary data.

- Monthly senior liaison meetings (or 'performance review meetings') will be scheduled between the co-ordination centre's designated contract manager and programme lead and the CQC surveys team manager. These will be scheduled to follow the monthly written programme updates described above, so that the management information contained in these updates can provide an effective framework for discussion against a standing agenda. The standing agenda will include a) progress on projects; b) priorities for the coming month; c) risks and mitigation; d) performance against KPIs; e) potential improvements or changes across the programme; and f) project costs and finances, including any under or overspend. The co-ordination centre's contract manager will chair these meetings, and the co-ordination centre will prepare minutes focussing on reporting of actions arising. Every third of these meetings could be extended to cover the requirement for a quarterly operational delivery meeting (as described in section 11, p.22 of the specification) without duplicating content. The extended meetings would, provide opportunity for a deeper review of some of the items likely to be covered as updates in standard monthly meetings.

- Work package specific meetings will be held at least quarterly, with a schedule of meetings to be agreed as part of the start-up for any new work package. The co-ordination centre will arrange meetings to coincide with key points in the timetable of each package, and we will handle any rescheduling that should be required in the event of timetable changes. Additionally to these pre-scheduled meetings, extraordinary meetings can be held for any work package if needed to respond to unplanned events (this may occur if, for example, a trust was unable to submit a representative sample for a national survey and discussion was required to agree whether they could participate). Meetings will be chaired by the co-ordination centre's programme lead or the work package project lead and the co-ordination centre will provide minutes of the meetings.

- An annual service and contract review meeting will be held once per year to review the co-ordination centre's overall performance and review how this is meeting CQC's business and strategic requirements. Minimally, co-ordination centre attendees will be the contract manager and programme lead.

- Each project will conclude with a project review meeting to discuss performance and identify areas of learning and future innovation. This is described in the project management section at 4.2 below.

- Outside of regular meetings, the co-ordination centre will stay in contact with CQC via a number of contact points:

    - CQC will have two named contact points for each work package, including a project lead and another member of staff who will be briefed on the project and able to cover absences. CQC will have email addresses and telephone numbers to give quick access to the full team of at the co-ordination centre.

    - A group email address will be established for each work package (for example, we currently use ip.cc@pickereurope.ac.uk for the national inpatient survey). The email address will be copied on all co-ordination centre correspondence regarding the survey, ensuring that co-ordination centre staff are easily able to access all correspondence relating to a given work package.

- For programme level queries, the Picker Institute's senior management team will be accessible via the contract manager and/or programme lead. Where the Director of Research & Policy is unavailable, another senior member of staff – eg the Chief Executive or Director of Communications – will be briefed on current programme status and available to cover any urgent requirements.

The set of meetings outlined are appropriate to large, long-term projects. The number and frequency of meetings should be proportionate to the work being undertaken and for smaller projects, such as those commissioned under work package 9, it would be sensible to agree a reduced number as part of the project planning. It will often be more cost effective for shorter meetings to be conducted by telephone or video conference: this will be agreed in advance with CQC.

To provide the package of communication outlined above, we will use a multi-tiered governance approach that will ensure that all members of the CQC team have appropriate contacts points within the co-ordination centre. This will involve a designated contract manager, programme lead, and project leads.

Contract Manager

The co-ordination centre's designated contract manager will be the [redacted] (see 5.5.1 below) [redacted] will serve as the main point of contact for any queries in relation to the overall management and monitoring of the contract, including reviewing performance against key performance indicators (KPIS). This role will also include the preparation and submission of monthly updates on costs and invoicing to the CQC surveys team manager, as well as a responsibility for monitoring the co-ordination centre's performance against agreed KPIS.

Programme Lead

The co-ordination centre's designated programme lead will be the [redacted] Survey Co-ordination, [redacted] (see 5.5.1 below). [redacted]ill take ongoing responsibility for management of work packages being undertaken by the co-ordination centre. This will include attending monthly liaison meetings and work package specific meetings to ensure line of sight across all levels of the work. [redacted] will be responsible for submitting fortnightly written reports to keep CQC updated on progress and risks; these reports are described further in 4.2 below. Any serious issues in performance or adherence to service agreements identified by the programme lead will be escalated to the contract manager for review and resolution.

Project Leads

Each newly commissioned work package will be assigned a designated project lead. Typically the project lead will be a senior research associate from the co-ordination centre team, although for some less complex projects – and with CQC's prior agreement – a research associate may be designated in this position (see 5.5.1 below for further information about staff within the team). Project leads will be responsible for day-to-day management of specific work packages, and will provide a routine point of contact for survey officers and analyst team leaders at CQC. They will have extensive direct contact with health & social care organisations participating in collections, giving comprehensive insight into the progress of work and any emerging issues. Where project leads encounter issues that may have implications across multiple work packages, they will escalate these to the programme lead.

Team administrator

In addition to the project, programme, and contract management tiers described above, the team will be supported by an administrator who will contribute across the co-ordination centre's activities. This role will provide an important support function, assisting colleagues to maintain timetables, update risk registers, and so on. This will be an important part of our overall management and monitoring approach.

Summary of co-ordination centre roles and responsibilities

[redacted]

[redacted]

Project management

For all projects, we will implement a rigorous project planning and management methodology. This will ensure that activities are designed to meet CQC's needs and will establish clear deadlines and deliverables that the co-ordination centre will be accountable for. Our approach is described in detail below and summarised in figure 3 on a subsequent page.

We understand that CQC will agree any work beyond the minimum expected level by preparing specification documents for the co-ordination centre to respond to. Our proposals to all such requests will be concise, as our standard approach to project management, communications, and so on is set out in this document and we wish to streamline outputs as much as possible to minimise burden on CQC. Proposals will focus on features that are specific to the new work package – including a detailed project plan and timetable, setting out the series of activities that will be undertaken. Project plans will provide a step-by-step narrative account of the actions required to complete the work: the timetable, presented as a Gantt chart using Microsoft Project, will show our proposals for scheduling the work. Proposals will be accompanied by a firm, itemised quote describing staff time and other costs.

The first step in any new work package will be a project initiation or start-up meeting with the CQC team. The aim of the meeting will be to ensure that the co-ordination centre team fully understand CQC's requirements for the work. This meeting will give the CQC and co-ordination centre teams the opportunity to discuss the proposed timetable for the work and agree any changes that need to be made to deliver on CQC's requirements. We anticipate that these meetings will include other standard items for discussion, such as establishment of a steering group (see 4.6 below); agreement of dates for future meetings; and so on. Meetings will usually be chaired by the contract manager or programme lead and will be minuted by the co-ordination centre. Co-ordination centre staff assigned to the project will also attend.

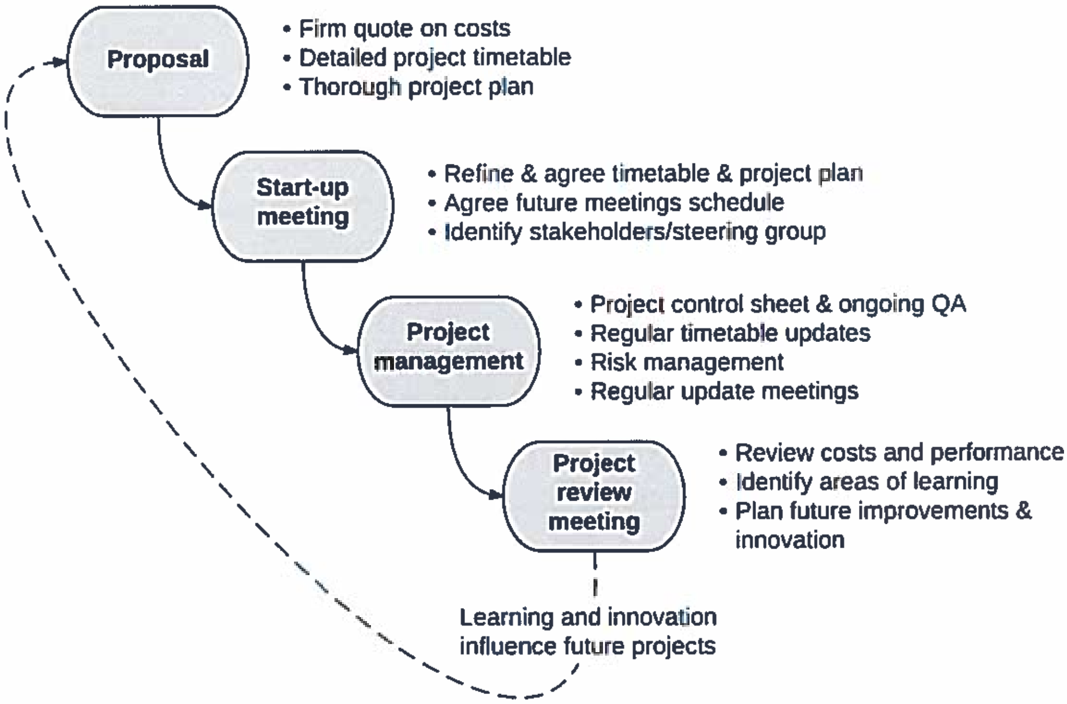
Once a project specification has been agreed and the start-up meeting completed, the co-ordination centre will enact its ongoing project management and quality assurance approach. A project control sheet will be created and stored in the electronic project folder, where all project materials will be placed. The control sheet will keep a record of all project documents (eg questionnaires; guidance manuals; reports; and so on) and will record creation dates, version numbers, and sign offs from the co-ordination centre and CQC. Importantly, it will include guidance for co-ordination centre staff on the level of internal sign-off required for different documents: published versions of documents such as questionnaires that can influence outcomes of surveys or other collections will usually require sign-off by both a senior research associate and associate director. This serves both to ensure that documents are checked and signed off prior to publication and allows an easy auditing of the project outputs. This control sheet, together with a folder documenting key decisions and sign-offs, both ensures our compliance with ISO 27001 requirements and will meet CQC's requirement, set out in section 12 (p24) of the specification for "a log [of] all decisions and actions… undertaken in delivering agreed packages of work".

All project files will be stored in a networked, access controlled project folder restricted to co-ordination centre staff. Survey project folders already follow a standardised layout, with a pre-defined structure that is saved in a template and replicated for new projects. A similar template will be created for other feedback mechanisms. To track progress, the project timetable will be updated at least fortnightly to monitor completion of work and to identify any areas where changes to the timetable are required as a response to delays, external factors, or changes in requirements. Summaries of project progress against timetables will be shared with CQC as part of fortnightly updates.

Throughout each project, all work is subject to the Picker Institute's standard quality assurance approach as set out in our quality manual (see 4.3 below). Also described in a separate section is our approach to risk management: this will be a core feature of all projects and risk management matrices will be routinely updated and shared, with mitigation actions discussed with CQC where required.

We see mutual learning and knowledge transfer as important features of our work. Accordingly, we propose that all completed work packages should be subject to a closing project review meeting. This review meeting, which will be attended by CQC representatives and the co-ordination programme lead, project lead, and other members of team involved in the project, will provide an opportunity to reflect on learning from the project. This will include a review of costs and performance, but also an open discussion about potential areas for improvement and learning. Meetings will be chaired and minuted by the co-ordination centre. The intent is that learning will be carried forward into new projects via improvements set out in project plans, such that our overall approach embeds basic principles of improvement science to focus on continuous refinement of our methods and processes.

- Figure 3: Summary of project management approach



Cost management

The co-ordination will provide a firm quote for each new work package as part of its proposal. We will commit to delivering the project at this cost level providing there are no substantial changes to requirements. However, to provide assurance to both CQC and to the Picker Institute, spend will be monitored throughout each project.

Each new work package will be assigned a separate project identity and reference number on our organisation's customer relationship management (CRM) system. This system already has a 'walled garden' area dedicated to the co-ordination centre, so costs and plans can be stored without being accessible to staff outside of the co-ordination centre team (see 4.8, below). Staff are able to record time worked on different projects, and will use this functionality to record inputs to work packages. This information can be collated at any time and will form the basis of updates on staff costs at monthly senior liaison meetings. Similarly, direct costs will be assigned to the appropriate work package and included in monthly summaries.

In order for monthly summaries to be useful they must not simply list spend – this will not adequately reflect the expected peaks and troughs in project spend. Certain stages of projects involve more intensive input than others: sample checking is, for example, considerably more resource intensive than other stages of fieldwork where the co-ordination centre's role is focussed on monitoring and supporting trusts. To help make sense of this, we will prepare projected cost schedules at the start of each project and represent monthly data both as absolute use and under/overspend against projections. This will give a far clearer sense of any potential issues or underspends, and will allow meaningful conversations about reconciliation and reinvestment of underspend where it occurs.

Quality Assurance

We are committed to delivering surveys, research, and service improvement in a way that ensures the highest quality of work. The Picker Institute operates an integrated Quality Assurance and Information Security Management System and is certified by SGS United Kingdom Ltd. to ISO20252:2012, the international standard for organisations conducting market and social research (certificate number GB08/74322). As part of our quality system, we maintain a thorough quality manual that sets out internal processes consistent with recognised industry best practice. These include, for example, clear recording of proposals, costs, key decision points, and authorisations for all projects; a version control approach; physical and environmental security; and a thorough internal audit process.

Our systems and processes include a comprehensives business continuity and recovery plan to ensure that the co-ordination's centres functions can be maintained even in the (highly unlikely) event of unanticipated disasters. We have procedures in place to ensure that any sub-contractors we use conform fully to our quality and information security systems.

In addition to the regular surveillance visits by external bodies we have our own auditing and quality and information security management team. With the help of feedback from our clients, the team continuously monitors the quality of service we provide. This commitment to continuous improvement is evident in our proposal for the co-ordination centre: broad feedback from users will be solicited via annual surveys of NHS stakeholders, whilst end of project review meetings will provide a platform for feedback from CQC and for learning and improvement.

We recognise that CQC has its own internal quality assurances procedure, including a QA manual for the Intelligence directorate. We have reviewed the content of this manual and can state with confidence that our own internal approach applies at least the same level of scrutiny in all cases.

Our full Quality Assurance and Information Security Management System manual is available on request. A full account of every feature of the manual is beyond the scope of this response document, but it is possible to set out key features that are particularly relevant to the co-ordination centre's approach and processes:

Data analysis & outputs

- Project teams prepare analysis specifications for data processing.
- Analyses are run using fully recorded and annotated syntax files, which are saved alongside original data to provide an audit trail.
- Outputs are checked for completeness and fully proofed. Co-ordination centre statistical outputs are checked by an additional member of staff using alternative data wherever possible to verify figures.
- Final 'reference' versions of survey datasets are saved to a common repository, accessible only to co-ordination centre staff.

Documentation

- Written client sign-off is recorded before commencing any project.
- Project numbers are shown on all key documentation.
- Any documentation that is confidential in nature is clearly marked and handled according to the procedures in our integrated quality manual.
- All documents related to a project are stored within a designated project folder, which is subject to a standardised structure.

Staff development

- All new staff follow a standard induction programme, which includes identification of any training needs.

- Staff appraisals are conducted at least annually & include a recording of training needs.
- Training is delivered through internal and external courses to ensure that staff have the skills required to excel. Delivery of training against requirements is audited through performance reviews.

Subcontractors

- The Picker Institute maintains a list of approved subcontractors, who are required to complete confidentiality agreements and confirm in writing that they conform to ISO 20252 and 27001 requirements.
- The performance of approved subcontractors is reviewed annually. This review and any action taken is documented.

Risk Management

Co-ordination centre projects tend to be complex packages of work: a typical life cycle will be in the order of a year, and surveys in particular have many stakeholders plus several layers of authorisations. Thus there are many external factors that have the potential to impact upon project plans. Proactive identification of these, and development of mitigation plans, is an important part of our project management and governance. We see risk management as so important that each of our case studies illustrates some of the most relevant risks and proposed mitigating actions.

We have a standardised approach to risk management. At the start of each project, risks are mapped in a risk matrix according to their likelihood and potential impact. Where appropriate, mitigating actions will be identified. These fall into two categories: firstly proactive mitigation strategies, where actions are taken to reduce the likelihood of a risk materialising; and secondly reactive mitigation strategies, where actions are planned to reduce impact in the event that a risk that is realised. Monitoring of risks will be completed via a 'status' column on the risk matrix: this will be updated at least monthly and will be assigned a simple 'red-amber-green' (see table 6, below) coding for ease of use and interpretation. Updated risk matrices will be shared with CQC via the monthly programme updates described in 4.1.1 above. CQC will be notified immediately in the event that any risk with a potential impact level of medium or above 'turns red' – that is, where a risk moves from being a possibility to a reality.

Table 3, below, illustrates our risk matrices. Please note that the examples in the case studies are intended to highlight relatively large risks only, so the 'impact' column is omitted – as is the 'status' column, as projects are yet to commence.

Table 3: Illustrative format of risk matrices for use by the Co-ordination centre

Risk	Likelihood	Impact	Mitigation	Status
Risk one	**High**	**Medium**		**Green: no immediate concerns**
Risk two	Medium	Low		**Amber: heightened risk**
Risk three	Low	High		Red: in progress

Recording and monitoring of risks is only one part of an effective risk management strategy. As detailed above, we will set out and be prepared to implement mitigation strategies for foreseeable risks. In the event of any new risks being added, or any medium or high impact risks being escalated to 'red' status, we will discuss and agree mitigation and/or recovery processes with CQC as soon as possible. This will generally involve input from either the programme lead and/or the contract manager at the co-ordination centre to ensure that actions are implemented swiftly.

Information Governance

Picker Institute Europe has UKAS accredited certification for its information security management system (ISO27001:2005) from SGS (certificate number GB10/80275). We also have a 100% score on version 12 (2014-15) of the NHS information governance toolkit (organisation reference 8HV74) and are registered under the Data Protection Act 1998 (Z4942556). All of our research is fully compliant with the Market Research Society's (MRS's) Code of Conduct, and we are registered as MRS Company Partners.

As part of our information governance approach, we have clear policies in place on management and use of confidential and identifiable data. Paper questionnaires and qualitative recordings are retained for six months unless another retention period is agreed with the client. Sensitive or confidential material is stored securely in line with our data protection policy: again, records are destroyed securely after six months unless a separate retention period has been agreed. Procedures are documented in our Quality Assurance and Information Security Management Systems manual.

As well as having a robust organisational policy around information governance, the co-ordination centre itself has exceptional knowledge and experience of dealing with issues related to confidentiality and data protection. We are highly conscious of the requirements governing the release of patient identifiable data from NHS trusts, and of the importance of section 251 of the NHS Act (2006). Section 251 (s251) is a provision of the Act that allows the waiving of the common law duty of confidentiality for defined medical purposes, including research. Support under s251 is essential to the NPSP, as it provides a legal basis by which patient names and addresses can be passed to contractors for survey administration without the prior consent of the patients involved. This is important as requiring prior consent –via patients 'opting in' to receiving questions – could be expected to seriously diminish effective sample sizes and fatally undermine the representativeness of survey collections.

Rightly, a high level of scrutiny is applied to applications for s251 support by the NHS Confidentiality Advisory Group (CAG), For the NPSP, CAG applications are routinely handled by CQC. We do, however, have considerable experience of supporting these applications, including by attending CAG meetings to help present the case for the work. We also have direct experience of seeking and receiving CAG approval and s251 for our own collections – including, for example, a national survey of parents' experiences of neonatal care conducted in 2014. Consequently, we are uniquely placed to support CQC in handling confidentiality issues related to the surveys and feedback mechanisms.

We have an organisational policy on safeguarding children and vulnerable adults, which is maintained in accordance with relevant legislation and is consistent with CQC's own approach. All staff receive formal safeguarding training.

Steering Groups

We understand that CQC is interested in establishing steering groups to support its surveys, feedback mechanisms, and related activities (including substantive reviews and piloting of improvements). Based on the specification (p.20) we understand that there is a requirement for the co-ordination to provide the secretariat of these steering groups, which we will be pleased to do. We assume that CQC will provide or appoint a chairperson for steering groups, but we are happy to support in this process or provide an appropriately skilled senior chair should this be required.

Secretariat

The function of the secretariat will, we anticipate, be to support and maintain the steering group. This will include a substantial administrative role that will be fulfilled by the co-ordination centre's team administrator (see 4.1.5 above). The administrator will compile and maintain contact databases for all steering groups, as well as collating and sharing terms of reference. They will distribute materials to members in advance of meetings as well as preparing paper copies of documents and other supporting materials. The administrator will also attend meetings, taking minutes and organising any additional support required (such as collating expenses requests and liaising with venues and caterers).

Expert support

We envisage that steering groups will benefit from expert input from researchers assigned to the relevant projects. To that end, we propose that project leads should be participants in all steering group meetings to avoid conflicts, they will be non-voting in the event that the terms of reference for steering groups permit votes on key decision points. Optionally, we would propose that the programme lead and/or contract manager should be invited to attend to bring more senior representation and a broader level of programme and content knowledge. The team's senior staff are used to participating in high-level project advisory and steering groups. For example, both Caroline Killpack and Chris Graham sit on the NHS Staff Survey Advisory Group, whilst Chris Graham sits on a variety of active steering groups including CQC's Integrated Care for Older People thematic review advisory group and the national COPD audit programme steering group.

In addition to attending the groups, we would like to highlight our ability to support CQC in the establishment of groups, should this be desirable. As an organisation we are extensively networked across health and social care and have a wide range of expert contacts from all sectors and backgrounds that we can draw on. We also have considerable experience of establishing and maintaining advisory and steering groups. For example, we have recruited and maintain a multi-disciplinary steering group for a NIHR Health Services & Delivery Research programmed funded study on measuring people's experiences of compassion in care: this includes a mixture of senior health professionals, third sector experts, academics, and patient and public representatives.

Stakeholders

CQC's collections, both via surveys and through other feedback mechanisms, have a significant profile in health and social care. They are used extensively for regulation, improvement, and public information. Accordingly, they each have a wide array of stakeholders in many different groups, from patients and the public to professionals and policy makers. It would be impractical and undesirable for all stakeholders to hold membership of project steering groups, so efforts are needed to ensure that the views of stakeholders more broadly are collected, heard, and acted upon where this is practical and mutually beneficial.

Stakeholder feedback about the co-ordination centre

The co-ordination centre is the key contact point for organisations participating in national surveys and in feedback mechanisms. It is important that the centre provides effective service not just to CQC but to this wider audience of end-users: participation in the programmes are not mandatory and the co-ordination centre has an important role to play in building good will and removing barriers to participation. CQC should therefore have assurance about the quality of service the co-ordination centre is providing to the organisations that the Commission regulates. To this end, we propose a series of activities designed to elicit feedback about the co-ordination centre.

Firstly, we propose an annual survey of participating organisations. This will be conducted via email and will be an opportunity for survey and feedback leads to give their feedback about working with the co-ordination centre and CQC, as well as to report their experiences of the collections and raise suggestions for improvement. This survey will be designed as a short online collection, to be disseminated via email, with a relatively small number of closed questions and a limited set of open questions for free text comments. The design of the questionnaire will be agreed and signed off with CQC prior to use.

At the end of the survey, the co-ordination centre will produce an open and transparent report of the findings for CQC, and will set out an improvement plan should there be any areas of concerns.

Annual feedback will work well with national survey stakeholders in particular, because this pattern of feedback corresponds with the lifecycle of surveys. For other feedback mechanisms, a different approach may be beneficial. For collections undertaken quarterly it would be more useful to gather feedback around a similar cycle. As such, we propose that key processes related to more frequent collections be evaluated with stakeholder feedback collected in-year. For example, our response to case study 6 sets out a proposal to collect feedback on the performance of guidance manuals through telephone interviews with provider staff involved in implementing collections. Because these manuals need to be reviewed after every quarterly cycle, an annual survey – or, indeed, a slower self-completion collection – would be less effective than this alternative approach.

As well as these planned quarterly and annual solicitations of feedback, we recognise that there are parties to the survey programme whose involvement is routine and ongoing: the approved survey contractors. It has been our experience that all of the approved survey contractors have been able to offer helpful suggestions in the course of running national surveys. Regular communication with these contractors is therefore important: not only do they have their own perspective on the challenges encountered in collections, but they provide an aggregation point for informal feedback from their clients. We thus propose to invite feedback from contractors through regularly scheduled approved contractor briefings.

It is possible that some elements of the co-ordination centre's work may be completed by subcontractors. We do not envisage that subcontractors would come widely into contact with stakeholders or end-users; however, where they do, we would require that similar quality monitoring data be collected from users about the performance of sub-contractors.

Avoiding conflicts of interest

In keeping with our commitment to transparency, we consider it important to set out how we will manage our organisation's dual status as the co-ordination centre and as an approved survey contractor, assuming we are successful in both lots of the current tender. As this dual status has existed for some time, it is easy for us to give assurances about how any potential conflicts of interest will be handled.

The Picker Institute have a dedicated survey implementation team who work as an approved contractor for NHS patient and staff surveys. Simultaneously, but separately, our survey co-ordination team manage the co-ordination centres for the NHS Patient & Staff Survey Programmes on behalf of CQC and NHS England respectively. This arrangement has been in place for the duration of the current NPSP, which has been operating since 2002, and since 2011 for the NHS staff survey. We have avoided conflicts of interest between our organisation's work as an approved survey contractor and as a co-ordination centre.

By having a strict system in place that ensures the survey implementation team do not have access to any information not available to other contractors for patient or staff surveys. This rule will be retained and strictly followed for the new co-ordination centre. The co-ordination team operate on a secure computer network, with all files relating to the management of the NPSP accessible only to members of the research & policy directorate. All communications with approved contractors (including the Picker Institute's survey implementation team) will be agreed in advance with CQC. At no time will the Picker Institute survey team receive preferential treatment or information prior to its wider release. In the extremely unlikely event of accidental disclosure of privileged information to the Picker Institute's survey implementation team – or, indeed, to any other approved survey contractor – we will notify CQC immediately and agree an appropriate resolution (this might, for example, include releasing the information to other contractors). In such an eventuality we would also conduct a full internal investigation to identify the cause of the disclosure and to put in place systems to preclude the possibility of it being repeated – but we must stress that in well over a decade of working both as an approved contractor and as a co-ordination centre the Picker Institute has never experienced an accidental disclosure of privileged information.

Having employed a successful system for a number of years we are completely confident that we can successfully avoid and deal with any conflict of interest that may arise. Moreover we would like to stress that our organisational expertise in survey design, development and implementation derives in part from our extensive experience of providing surveys to NHS trusts and other clients. Such knowledge is vital for the co-ordination centre role and we believe an organisation that lacked experience of working as a survey provider would be unable to fulfil this function adequately.

Experience and team

Throughout this document, we have described our understanding of the requirements for the co-ordination centre and our proposals for undertaking its work in future. In this section, we will outline our expertise and how this qualifies us to fulfil each element of the co-ordination centre's responsibilities as a strategic partner for CQC. This section will also cover the resources we plan to utilise to deliver the co-ordination Centre to fulfil the standards set by CQC, including an additional resource approach to support the team as extra work is commissioned.

Picker Institute Europe

The Picker Institute is a charity committed to a vision of the highest quality health and social care for all, always. We are widely recognised as one of the world's leading organisations in our field.

The Picker Institute's team have unparalleled experience and expertise in collecting & using patient and service user feedback from national surveys and other methods. Our research partnerships with leading universities, hospitals, and charities enable us to develop and share a better understanding of both outcomes and experiences of care in the NHS. Our work with governments, their agencies, and regulators, helps to ensure that this insight is translated into health and social care policy and practice that supports the delivery of high quality person centred care for all. Moreover, we work extensively with NHS organisations that provide and commission services. In the acute sector, for example, we work directly with more than half of all provider organisations to undertake and report on their patient experience surveys.

Design and delivery of surveys

The majority of the co-ordination centre's role will involve the design and delivery of surveys within the NPSP. This requires a unique combination of skills, particularly because the devolved administration of devolved collections raises challenges that are not typically found in centrally administered surveys. To be effective, the co-ordination centre must possess not only a deep understanding of survey methods, but also experience of supporting third party organisations (often with minimal research experience themselves) to successfully implement high quality collections.

Survey co-ordination

We have acted as **the NHS Patient Survey Co-ordination Centre** for CQC, and its predecessor organisations, since 2001/02. Over the last fourteen years, we have collaborated with the regulator on almost 50 national surveys collecting over 2,400,000 responses. Every single survey in the NPSP has been built on Picker Institute questions and/or substantively designed and developed by the Picker Institute. Since 2011, we have also managed the **NHS Staff Survey Co-ordination Centre** on behalf of first the Department of Health and, more recently, NHS England. We have accumulated more experience than any other UK organisation of designing, implementing and analysing co-ordinated national surveys.

As **the NHS Patient Survey Co-ordination Centre** we have established a proven track record of delivery as well as introducing a variety of improvements to individual collections and across surveys. Throughout this document, we have described examples of our work and plans for the future. Here, we highlight some key examples that demonstrate the strength and depth of our experience.

Development of new surveys

In our role as the co-ordination centre, we have overseen the development and co-ordination of all surveys within the current NPSP[1]. Each of these surveys has involved extensive background work and primary research to develop questionnaire content and identify appropriate sampling

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and administration methodologies. Below, we give one example of our approach to the various stages of survey development.

The 2013 ambulance 'hear and treat' survey

The 2013 ambulance 'hear and treat' service users survey was the first national survey targeting ambulance service users since 2008's 'category C' ambulance survey. 'Hear and treat' refers to a growing category of ambulance service users who receive advice over the telephone only, and are not normally attended by an ambulance crew. The survey covered each of England's ten ambulance trusts and was particularly remarkable as it was the first in CQC's national programme to use a telephone survey (CATI) methodology. This methodology was selected following initial consultation with stakeholders, when it became apparent that ambulance services would not have reliable address details for callers.

The survey was challenging because of a lack of prior evidence about users of 'hear and treat' services; inconsistent sample frames; and variation in practice around how services are delivered locally. To develop the survey, we therefore followed a multi-stage approach including:

- Initial **scoping** discussions with CQC and key stakeholders, including ambulance trust representatives, to understand the requirements and key parameters for the survey. This involved written correspondence and face-to-face meetings and established that a postal survey would be out of the question.

- A **sampling pilot** to test the feasibility of identifying eligible users from ambulance service records. Pseudonymised data from all English ambulance trusts was collated by the co-ordination centre and analysed in terms of quality and completeness. Alongside this, we collected feedback from each trust about the sampling process, including any challenges or barriers that they faced. The sampling pilot highlighted some potential problems that we were able to address through revisions to guidance (such as asking trusts to submit censuses, rather than conduct sampling themselves).

Once the feasibility of the survey was established, further **consultation** was undertaken with stakeholders to help shape the content of the questionnaire instrument. We were able to identify a number of areas of consensus that would need to be covered in the survey. This stage also identified a logistical challenge, as each trust used one of two call handling systems, NHS Pathways and MPDS, which involved different patient flows. To understand these systems, co-ordination centre researchers visited two trusts to listen to live 999 calls and gain a practical understanding of how services and pathways respond.

Two **focus groups** were undertaken, each with ten recent service users and facilitated by co-ordination centre researchers. Groups were transcribed and discussions reviewed thematically, enabling us to identify a number of priority issues related to user experiences of 'hear and treat' services.

Subsequently, we **designed a questionnaire** to cover the themes identified. This included items adapted from other NPSP collections as well as a significant number of wholly new items. The development of this questionnaire illustrated our flexibility, as it was the first CATI survey in the NPSP.

The draft questionnaire was evaluated via three rounds of 12 **cognitive interviews** (36 total). Interviews were conducted face-to-face, but to replicate the conditions of a telephone interview all questions were read aloud to participants. Interviews were conducted by either Picker Institute or CQC staff in order to build shared understanding of the effectiveness of the questionnaire. Issues arising were discussed in mutual debrief sessions at the end of each round, & changes were introduced into the questionnaire for the following round.

Ethics and **section 251** approval for the survey were sought and obtained, and delivery of the survey was undertaken by a subcontractor procured and managed by the Picker Institute (with representation from CQC on the procurement panel).

Ultimately, the thorough development process meant that we were able to plan and implement a successful survey in an area previously not covered by any national survey collections.

Substantive review of existing surveys

Because the NPSP already includes a suite of developed surveys, it is often the case that wholly new development of surveys is unnecessary. However, not all existing surveys can or should be simply repeated; sometimes the methods or content will be affected by policy or practice changes in the NHS that mean that a deeper review is required. We have extensive experience of undertaking this kind of substantive review to update and revise programmes within the NPSP.

As an example, we undertook a substantive review and redevelopment of the Community Mental Health Survey in 2014. This involved a literature review, desk research on changing patterns of mental health service provision and use, secondary analysis of data from the 2013 survey, and a series of stakeholder engagement workshops to canvas views from academics, leading mental health practitioners, CQC representatives across different teams, NHS England, and the Department of Health. These activities led to a revised questionnaire being developed and tested through four rounds of cognitive interviews prior to its use in the 2014 national survey. The full development report is available at http://www.nhssurveys.org/Filestore/MH14/MH14_Development_report_v3.pdf.

Ongoing development and delivery of national surveys

As described, we view repeated national surveys as following a continuous lifecycle of implementation, learning, and improvement. Whilst we certainly recognise the advantages of maintaining year-on-year consistency in collections (in order to build and use a time-series of results), we are equally keen to ensure that the surveys stay up-to-date and benefit from the latest methodological innovations. Our experience of developing and piloting survey methods changes and innovations is set out in a later section, but below we briefly describe our experience of the ongoing development and delivery of one survey.

Adult inpatient survey 2002-2015

The adult inpatient survey is widely regarded as the flagship of the NPSP. First conducted in 2002, the survey has now been completed on twelve occasions, amassing over 800,000 responses. As one of the largest and longest established collections of patient experience information in the world, maintaining consistency in year-on-year results is hugely important – not least because the survey forms the basis of a National Statistic on patient experience. Consequently, much about the surveys content and methodology has remained relatively unchanged – but we have, nonetheless, been able to learn from administering the survey and introduce a series of changes and improvements that have improved the quality and utility of the survey.

In 2006 we introduced two new elements to the survey: **sample checking** at the start of the survey and **weekly monitoring** of progress during fieldwork. These changes were designed to prevent errors from trusts administering the survey, & have successfully prevented many serious errors in sampling. Both processes are now standard for all surveys in the NPSP.

In 2011, we made extensive changes to the **covering letters** used in the survey to make their text more accessible and to allow for the inclusion of patient names and titles. This was done in a bid to improve survey response rates and – whilst the changes cannot be proven to be causal – the survey recorded a very large 3.5% point rise in response rates compared to 2010: the first year-on-year rise in response rates recorded in the survey.

In 2015, we are increasing the survey **sample size** from 850 patients to 1,250 patients per trust; this is described further. This will improve reliability of survey data for all trusts and will allow more granular reporting. Simultaneously, we are introducing the collection of **ICD-10 chapter**

codes as part of the sample data for the survey: taken together, these changes will enable the comparison of the experiences of people with different types of condition, greatly extending the value of the survey with minimal increase in central costs.

In addition to these methodological changes, the questionnaire for the survey has been reviewed every year and revised where appropriate: this has enabled it to keep pace with changes in priority areas for the NHS. Over the years we have added of new questions covering contemporary priority areas as diverse as hand-hygiene, use of patient feedback, mixed sex accommodation, and relational aspects of care.

Piloting changes and innovations

Not all changes to surveys can be accommodated within the usual cycle of delivery and development. Larger changes, and particularly those with the potential to affect survey outcomes, require thorough testing first. We have described above our experience of undertaking a sampling pilot as part of the development of the 2013 'hear and treat' survey of ambulance service users. Additionally, we have successfully designed and implemented a series of experimental pilots focussing on different elements of survey design and methodology. These have ranged from relatively straight forward pilots, such as concurrent offering of an online survey mode for the 2012 A&E Survey, to more complicated experimental design pilots – such as one investigating response rates that we are currently co-ordinating for the 2015 Inpatients Survey. In all of our piloting, we look to assess whether changes can feasibly be made; whether they are cost effective in terms of delivering improvements; and whether they affect the integrity or comparability of survey data.

Where piloting indicates that changes are feasible and desirable, we have strong experience of making transformative changes to surveys. Perhaps the best example is the changes that we (in partnership with NHS England) have made to the **NHS Staff Survey** since taking over the management of the survey in 2011:

Allowing participating organisations to collect data **online** instead of using paper forms: a shift from a traditional postal survey to a more modern mixed mode design. To avoid disruption to the national survey, which is a key source of data on NHS performance, we have worked with partners and our advisory group to introduce changes gradually. To do this, we have set a data quality threshold regarding recording of e-mail addresses. This was initially very high – effectively restricting the online option to trusts with the most experience of electronic communication – but has been gradually relaxed. For 2015, we will be removing the threshold altogether, allowing all trusts to use a mixed mode approach.

Allowing trusts to survey an **extended sample** or **census** instead of a maximum sample size of 850 staff members: addressing demand from employers to be able to include data from all of their staff in benchmark results from the survey.

The net effect of these changes has been to allow trusts to undertake the survey with a massively reduced unit cost and with a vastly increased sample size. In one extreme example, an acute trust previously restricted to a sample of 850 patients now surveys their entire workforce of 17,000. Because this workforce is surveyed online, the trust's costs have not risen but the data available to the co-ordination centre, NHS England, and the trust is much more reliable. Overall, the sample size of the survey as a whole has tripled, from around 200,000 in 2012 to 624,000 in 2014 (the latter representing around 40% of the eligible workforce).

Experience of ethical and confidentiality considerations

As outlined our understanding of ethical principles and data security requirements of research studies is substantial. All research is undertaken in compliance with the principles of the MRS Code of Conduct and is subject to the Picker Institute's own research governance framework, with projects obtaining NHS ethical review wherever required. All researchers within the team are fully experienced in compiling ethical applications leading to successful approval of national surveys. Additionally, we have full IG toolkit accreditation and a strong understanding of the requirements of Section 251 for each of the national surveys.

We have been able to use our experience of ethics and confidentiality issues to introduce specific improvements into survey processes to better uphold the information governance and data security conditions around the national surveys. For example, the introduction of the sample declaration form to reduce the number of information governance breaches, and the process for the co-ordination centre to receive both care cluster data (Community Mental Health Survey) and postcode attribution data (Maternity Survey).

Stakeholder engagement

In our experience of co-ordinating the survey programme, we are acutely aware of the need for engagement with stakeholders and clear communication with all parties involved in the administration of the NPSP. We have introduced a number of initiatives across the programme that have greatly added to the success of the programme using a devolved method. For example, we have successfully introduced approved contractor briefings and trust webinars for all surveys within the NPSP. These initiatives have enabled us to streamline the survey processes to better enable trusts and approved contractors to implement the survey as designed, allowing for robust, high quality data to be collected that is fit for purpose. We are also constantly reviewing how we can improve the communications process with more streamlined survey materials, such as the guidance manuals, and a schedule of proposed e-bulletins with outlined content so all parties are aware of the survey stages.

Analysis and reporting

An important aspect of the development and delivery of the NPSP is the routine analysis and production of the standard outputs for the surveys. Since 2009, we have undertaken statistical standardisation and benchmarking analysis across the programme, activities previously undertaken by CQC's predecessor organisation, the Healthcare Commission. This work is supervised or directly undertaken by the Picker Institute's chief statistician, Dr Steve Sizmur, to ensure the quality of outputs, and all results are subject to thorough quality assurance as described in section.

We have also produced the other standard outputs (national comparative tables, percentage level data, website data, Intelligent Monitoring Data, NHS Patient experience domains) alongside bespoke and additional reporting for a number of surveys, such as A&E, the 2014 Children's Survey, and Community Mental Health. We have continually reviewed the outputs to ensure that they are meeting the needs of stakeholders and for different surveys we have worked to produce bespoke, or tailored reports such as children facing benchmark reports for the Children's Survey. We have also undertaken free text analysis for both the adult Inpatient and Maternity Surveys, and analysis of the drawings submitted for the Children's Survey. In line with this we have produced accompanying guidance manuals to support the use of the different reports and to highlight to trusts how they can use their data more readily. For the 2015 Community Mental Health and Maternity surveys we will also be working with CQC to determine what analysis can be undertaken with the care cluster and attribution data respectively, to enhance the outputs given to trusts.

Approved Survey Contractor for the National Staff and Patient Surveys

As well as providing the NHS Patient Survey Co-ordination Centre, the Picker Institute has been an Approved Survey Contractor for the NHS Patient and Staff Survey programmes since 2002. To date we have surveyed over two million patients and over half a million staff as part of these programmes alone.

In this role, our organisation regularly works with a large number of NHS trusts to deliver and support the surveys and has a thorough understanding of the practical realities of implementing surveys. This includes running free-to-attend action planning workshops to help trusts translate their patient and staff survey results into meaningful improvement.

As described in section, we maintain a strict 'Chinese Wall' between the survey co-ordination & the approved survey contractor elements of the organisation. This ensure that the co-ordination centre can act with impartiality and that there is no suggestion of conflicts of interest in the management of the survey programme.

Other feedback mechanisms

The role of the new co-ordination centre will extend beyond the management of the NPSP to cover other feedback mechanisms used by the CQC.

Delivery and collection of feedback

The other feedback mechanisms are likely to feature a substantially greater implementation and delivery role than the devolved national surveys, and our organisational experience of managing this kind of work is well exemplified by our approved contractor status. Furthermore, we have strong experience of subcontracting with suppliers to undertake the distribution of questionnaires and collection of data. We have used this approach in the 2013 'hear and treat' survey, as described, as well as in many of our own studies outside of the NPSP. Below, we set out two examples that, by their marked differences, exemplify the breadth of our experiencing in collecting feedback.

Neonatal survey

The Picker Institute have worked with Bliss, the charity "for babies born too soon, too small, too sick", to develop and run a national survey of parents' experiences of neonatal care in 2011 and 2014. The survey covers a delicate and sensitive issue – the care in hospital of newborns who need extra support from special care baby units, local neonatal units, or neonatal intensive care units – and one where evidence on user experiences was previously lacking.

Our first survey was conducted in 2010, developed in conjunction with Bliss and supported with funding from the Department of Health. Survey development activities included a literature review, four focus groups with parents, and a series of cognitive interviews. Development was led by [redacted] The new questionnaire was administered in three waves, each three months long, to ensure adequate sample sizes from the often small services without asking parents to report on events that had happened many months previously. Administration was undertaken by one of the Picker Institute's approved subcontractors, closely managed by the survey co-ordination team.

At the end of the survey, which received an excellent 50% response rate, data was collated and cleaned by the Picker Institute. Question domains were created following a thorough factor analysis conducted by [redacted] and results were presented back to each of the 125 participating organisations in a comparable format. Key findings from the survey, including an account of the overall development, were published by the Picker Institute [redacted]

Notably, we were able to employ an innovative 'peer review' approach to anonymisation of potentially sensitive verbatim comments received as part of the survey. Because many neonatal units are small, and treat a relatively low number of newborns, there was concern from the survey advisory group that comments seemingly innocuous to researchers may identify individual patients or staff when viewed locally. We recognised that the people best equipped to identify potentially disclosive comments were those with the most experience of managing neonatal. units. As such, we were able to recruit neonatal network leads to act as reviewers. Each reviewer was sent a proportionate random sample of comments relating to organisations other than their own: they reviewed these and redacted potentially disclosive comments. Unique reference numbers were used to match redacted comments back to the main survey dataset, enabling us to provide thoroughly anonymised comments back to participating organisations in spite of the small and sensitive population of interest.

'Frequent Feedback'

As a dynamic and forward thinking research agency we understand the importance of matching the correct research approach to the target patient population, and the needs of the organisation commissioning the work. As well as our expertise in statistical sample surveys, we have a wealth of experience in collecting and user 'near real-time feedback'. This involves the collection of data at the point of care using a variety of methods. Whilst these methods tend to be more appropriate at the local level, the tools that are used for collecting the data can be more widely applied. Importantly, the experience of developing and using this approach, which focuses on rapidly producing local intelligence without the focus on robust comparability in the NPSP, closely mirrors the nature of the other feedback mechanisms used by CQC.

The Picker Institute offers a mobile and flexible 'Frequent Feedback' methodology, using hand-held devices, programmed with specially designed surveys that are administered at the point of care. Multiple surveys can be programmed onto a single device, and be provided in different languages, easy read (larger fonts), different colour schemes or the inclusion of pictures, graphics or video clips. We have worked with over 20 acute trusts, hospices, and private sector organisations using the handheld methodology. For example, we have been working with a specialist cancer care NHS foundation trust since 2009 developing a number of their surveys on portable devices.

Collection of 'Frequent Feedback' is often supported by hospital volunteers who we train to administer the surveys. The use of volunteers has proven effective in reducing staff burden but also reducing survey bias by not using frontline staff to administer the surveys: our experience of training volunteers is pertinent and could in future be applied to supporting CQC inspectors and/or Experts by Experience. We are currently in the process of trialling the effectiveness of this methodology as part of a major 30 month study funded by the NIHR's Health Services and Delivery Research (HS&DR) programme: this study is being led by [redacted] and is collaboration with colleagues at the University of Oxford.

Since the launch of the NHS Friends and Family Test (FFT) in 2013, our programme of 'Frequent Feedback' has been extended to help trusts fulfil their new requirements. In our work with trusts in delivering their Friends and Family Test (FFT), we have introduced the use of SMS text messaging to invite respondents to complete the FFT online or via SMS with respondents able to submit their feedback either via text message or by clicking a link (within the text itself) taking them to an online version of the FFT. Our collection of FFT data with a number of trusts and using a range of methodologies enabled us to complete and publish an important study conclusively demonstrating that the FFT was not, contrary to prior claims, capable of producing comparable data suitable for evaluating institutional performance [redacted]

Adult social care

Work packages related to 'other feedback mechanisms' are expected to be focussed in adult social care settings. We have experience of working in adult social care, and particularly in some of the services identified in the specification, such as hospices.

In 2013, the Picker Institute and the King's Fund, a regular partner and collaborator, were commissioned by CQC to investigate the feasibility of establishing new national surveys of adult social care (Picker Institute Europe & King's Fund, 2013). To complete this work, which took the form of a rapid three month review, we used a mixed methods approach involving landscape mapping, stakeholder consultation, desk research; and scenario modelling. This work was able to identify and investigate a broad range of issues related to the methodological and practical feasibility of surveying users of social care. This identified many challenges to producing robust, comparable data for this setting in the same style as the NPSP used in healthcare; this supports the CQC's use of other feedback mechanisms as a practical alternative.

Relevant to CQC's requirements, we have undertaken a number of projects looking at end of life care and hospice services. We recently undertook a project involving qualitative research (patient stories) with patients receiving palliative care from Cumbria Partnership NHS Foundation Trust. The research formed part of a review into the provision of services and to aid understanding of the issues faced by those in the last year of their lives. Interviews were conducted in both patient homes and hospices. Similarly, in 2011, we also conducted qualitative research commissioned by the Motor Neurone Disease Association (MNDA) to investigate the needs and wishes of people with Motor Neurone Disease (MND) in the areas of dying and end of life decision-making. In both cases these projects covered potentially sensitive content around people's views on death and dying, but we were able to develop effective approaches that balanced ethical and methodological requirements to produce insightful evidence.

Finally, it is worth briefly noting that the team have direct practical experience of involvement in CQC's other feedback work in social care settings. The team's director, [redacted] was previously a [redacted] and led on a [redacted]

Other experience

In addition to describing our experience of developing and delivering surveys and other feedback mechanisms, it is useful to set out some of our wider experience: this helps to illustrate the team's capacity to function not just as a provider, but as a very credible and reputable strategic partner for CQC.

Quality improvement

Another area in which we have been successful over a number of years is the drive for improvements in service delivery and quality of care at the local level. For many years, we have worked with different organisations, ranging from acute trusts to clinical commissioning groups (CCGs) to evaluate services and identify priority areas for focussing improvements. One recent project undertaken with NHS Greenwich CCG focussed on GP registration and aimed to understand why some residents were not registered with their GP practice, and to highlight issues where residents had required support in registering. Qualitative research including in depth interviews and observation work with local residents identified a number of actions that the CCG could take to addressing the issue of non-registration. These changes included reviewing the language services offered, information about entitlements, and closer working with community and support organisations. The CCG is currently planning initiatives areas to address these findings, with support from the Picker Institute.

Working with trusts to identify and implement improvements based on the findings from the national surveys is an area that we have vast experience in. For each national survey, the approved contractor team at the Picker Institute facilitate workshops with clients aimed at producing workable action plans for service improvements. Regional workshops are also run to enable trusts in the same geographical area to share best practice and learn from each other: this shared learning approach is a useful and highly valuable method which has led to improvements in a number of trusts, and the establishment of learning networks.

The Picker Institute have also been working with different trusts to produce triangulated data reports – 'patient experience reviews' – pulling together service user feedback from a variety of sources namely the Friends and Family Test, NPSP, and voluntary surveys. These reports provide a comprehensive understanding of patient and staff experience, whilst identifying common themes arising from all data sources, assisting trusts focus improvement initiatives and share best practice.

In parallel to working with individual healthcare providers to drive forward changes in services, we are also involved in improvement at a national level. We are currently collaborating with NHS England and the Institute for Healthcare Improvement on a joint initiative called Always Events. The basis of Always Events is an improvement programme that seeks to place recipients and users of care, and their families/ carers, at the centre of collaboratively designing the process of care delivery with health care professionals. In effect, they cover aspects of care that should always happen.

International experience

Our reputation as an expert in patient experience research is not limited to the national stage. The work and reputation that we have built over the past fifteen years also resonates at an international level. Surveys that we have designed are currently being used across the world: elements of the adult inpatient survey are recommended by the Organisation for Economic and

Cultural Development's (OECD) subgroup on the international measurement of patient experience, and the survey is used in whole or in part in countries across four continents. Moreover, the team responsible for implementing the survey co-ordination centre have provided consultancy services to agencies across the world and have been instrumental in the design of survey programmes in nations such as Iceland, Hong Kong, Italy, Switzerland, and Germany. The involvement of the Picker Institute as a consultant demonstrates the reputation and expertise that we have as one of the leading agencies in this field on a world level.

Vulnerable and seldom heard patient populations

Central to the ethos of the Picker Institute is making voices of patients, service users, and their families and carers heard – and using that feedback to drive improvements in health and social care for all. One area where we have made significant strides is in accessing 'hard to reach' patient populations or those groups who are 'seldom heard' at the national level. This is exemplified both by our work with people at the end of life, described above, and by several recent projects, which are described in brief below.

We are currently working with the Sickle Cell Society and NIHR to develop survey tools that can be rolled out nationally to gather feedback and measure the experience of people with sickle cell disease ('NEW tool to understand and improve care for patients with sickle cell disorder launched nationwide', 2015). In 2012, we undertook research with parents/ carers and young people focussing on the measurement of experience for people with life limiting genetic conditions and using transplant services, on behalf of the National Specialised Commissioning Team (NSCT). This work involved designing a toolkit that could provide a baseline, and subsequent longitudinal data, for all services commissioned by NSCT.

We have a particular expertise in research with children and young people, with the Picker Institute Paediatrics Inpatient Survey being licensed by CQC to form the basis of the national 2014 Children's Survey. We have also worked with Birmingham Children's Hospital to develop a child friendly FFT tool, in conjunction with Monkey Wellbeing (see http://www.pickereurope.org/case_studies/recommending-friends-family-test-fft-children-young-people/ for details). There also plans for the NHS Outcomes Framework to include an indicator on children and young people's outpatients care using questionnaire items sourced from the Picker Institute tool. Further research activities have been conducted on behalf of CLIC Sargent, to explore what was important to their users and what could be improved in terms of the service they provide to young people with cancer. We have also worked alongside the Royal College of Paediatrics & Child Health (RCPCH) to develop a series of Paediatric.

Urgent and Emergency Care surveys for children and parents.

We are currently working with the British Heart Foundation (BHF) on a research project exploring attitudes towards statins among high-risk patients, GPs and cardiologists, to better understand the extent to which concerns about side-effects are affecting treatment of high-risk patients. The study involves interviews, discussion groups, and online surveys with patients, GPs and cardiologists. Findings from the research will inform BHF's activities to promote cardiovascular health and prevent cardiovascular disease. The research will help understand what influences attitudes and behaviours, from which we will develop a set of key questions to be used in a quantitative survey to measure the extent to which behaviour may be affected by concerns about side-effects.

In addition to this a number of the voluntary collections undertaken by the trusts we work with are delivered as online surveys. The use of online response has been trialled on various occasions within the NPSP.

Statistical analysis and modelling

We have extensive experience in applying complex statistical analysis to investigate issues related to the experiences of patients, service users, and staff.

In 2013, we investigated mode effects on response rates and patterns associated with online response to the NHS Staff Survey. This included multilevel linear and logistic regression modelling of responses to detect any potential bias to survey responses attributable to online responding. In 2014, Picker Institute Europe was contracted by the General Medical Council to undertake a complete evaluation of the National Trainee Survey. This project included qualitative review of the questions and their presentation against best practice. We also conducted an extensive psychometric analysis of question performance, including respondent-level and provider-level reliability, analyses of the response data including comparisons of data structure over different respondent groups using confirmatory factor analysis models, and a critique of the benchmarking approach in use at the time.

Health services and policy research

Our expertise is not limited to our survey research activities, but extends to health services and policy research at a national and international level. Our research team works closely with high profile academic and third sector partners including University of Oxford, the King's Fund, and the Nuffield Trust. We are a partner member of the Oxford Health Experiences Institute (HEXI; http://hexi.gtc.ox.ac.uk/index.php/people-and-partners/hexi-partners), of Oxford Academic

Health Science Network, and the Coalition for Collaborative Care (http://coalitionforcollaborativecare.org.uk/aboutus/our-partners/). The team's director, Chris Graham, is an associate member of University of Oxford's Health Services Research Unit at the Nuffield Department of Population Health.

We have worked on a number of key policy driven research projects surrounding integrated care and After Francis. For integrated care we have undertaken work on behalf of the Department of Health evaluating options for the measurement of integrated care, and design of specific items for measuring integrated care [redacted] Since then, we have also been working with a number of partner organisations (National Voices, Nuffield Trust, King's Fund, International Foundation for Integrated Care) to develop a tool that captures the experience of older people with chronic conditions about how effectively their health and social care is co-ordinated across organizational boundaries.

We are also undertaking an NIHR funded 3 year research project to strengthen organisational capacity to deliver compassionate care in the NHS. This project includes the development of a survey instrument to measure relational aspects of care, as well as the collection of patient experience data using tablet computers. Based on the research findings, evidence-based recommendations for the introduction and use of near-real time feedback will be developed and disseminated to trusts across England.

In addition to our research work, we undertake dynamic policy pieces using the national survey results, such as issuing policy briefings on A& E waiting times, and briefings on staff wellbeing. These pieces of work take the research findings and translate them into policy recommendations for the wider policy context.

Our team

The Picker Institute have a skilled and versatile workforce comprising 50 staff members in our Oxford headquarters and an additional six in our Hamburg office. In keeping with existing arrangements, the co-ordination centre will be managed by the organisation's research and policy directorate in Oxford. The directorate includes fourteen members of staff; a multidisciplinary group including researchers, the organisation's chief statistician, and policy staff. As we will describe further below, the co-ordination centre will also be able to increase resources as needed through use of the wider team at the Picker Institute; our partners; and approved freelancers.

Survey co-ordination team

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

Additional resources

The co-ordination centre possess excellent experience in survey research methods and have demonstrated, through our successful management of the existing NPSP, our capacity and capability to manage all work packages relating to patient surveys. However, we recognise that the role of the new co-ordination centre will be extended in its coverage of other feedback mechanisms, and note that CQC's intention to commission work packages individually within the contract period means that there may be situations where it is necessary to increase the resources available or bring in specialist expertise. We are confident that our organisational structure and approach affords the flexibility to identify and engage additional resources rapidly and effectively. Normally, we envisage identifying appropriate resources to deliver each work package as part of our proposal to for details.

In many cases, we will be able to provide additional resource and expertise from within the research and policy directorate – particularly from our experienced and highly skilled research team. Because the Picker Institute operates more widely as an expert on patient experience research, it may also be possible to bring in additional resource from elsewhere in the organisation as circumstances require. Beyond this, we benefit from access to a pool of approved freelance staff – experienced, expert researchers who have a proven record of working with the Picker Institute, and who in many cases have direct experience of working on surveys within the national programme. Finally, our extensive networks, partnerships, and list of approved subcontractors enables us to access external resource quickly when needed. Here, we provide examples of individuals from each category.

[redacted]

[redacted]

[redacted]

Schedule 3

Pricing Schedule

Milestone payments

At the start of any package of work a timetable detailing payments for that package will be agreed between CQC and the Co-ordination Centre. It is expected that proportional payments will be made at three points in each package: completion of development and review, completion of analysis and report development, and completion of the work package.

Where a commissioned work package relates to the collection of feedback CQC will agree payment points based on: completion of scoping and development; completion of field work or data collection, and completion of agreed outputs.

Payments will be conditional on the achievement of those milestones set out above and the achievement of the key performance indicators set out in section 11.

The exact payment value and date of milestones will be agreed by CQC at the time of commissioning any work package.

Cost

This document sets out the co-ordination centre's costs against each of the nine case studies described in CQC's specification and in our attached responses. All of our costs correspond to the activities and processes described in our case study responses. To aid interpretation, we have broken costs down into separate sections as well as individual activities. In some cases – notably the pilot described in case study 5 – there are optional cost segments that could be removed.

Elsewhere, it is important to note that costs correspond to the specific example given in the case study, and could vary for different examples within the same work package. As outlined in the project management section of our main response, however, full itemised costs will be prepared as part of the proposal for each work package.

As requested, our costs for the case studies incorporate the central costs of providing the co-ordination centre. This assumes that at least the minimum level of work described in the specification is required.

Finally, we are pleased to report that all of the costs presented include a substantial **discount** of up to 18% on our standard day rates. This reflects the volume of work and also the value we ascribe to our continuing relationship with CQC.

Worked example

We recognise that the costs submitted include a considerable level of detail and are complex. To assist with interpretation, we therefore present a worked example of the annual cost of the co-ordination centre below. This is based on CQC's 'expected minimum' programme of work (p5 of the specification) and includes the following packages of work – each with the corresponding work package shown in parentheses.

- **National Surveys**
    - Substantive review and delivery of the adult inpatient survey **(WP2)**
    - Substantive review and delivery of the children's survey **(WP2)**
    - Substantive review and delivery of the outpatients survey **(WP2)**
    - Ongoing development and delivery of the community mental health survey **(WP3)**
- **Other feedback mechanisms**
    - Substantive review and quarterly collection, analysis, and reporting on feedback for community based care **(WP5)**
    - Substantive review and quarterly collection, analysis, and reporting on feedback for shared lives **(WP5)**
    - Substantive review and quarterly collection, analysis, and reporting on feedback for hospice care provided in people's own homes **(WP5)**

Each work package corresponds to one of the case studies. For case study 5, we have included costs for a pilot as an optional component – but we assume that none of these pilots would be included in the minimum programme of work. The overall annual cost of the co-ordination centre based on the above assumptions is as follows:

[redacted]

Total annual cost, excluding VAT, for all work packages:	**£946,263.93**

Based on this, we estimate the total minimum contract cost to be £1,892,527.86 excluding VAT over the initial life of the contract. We note that this is close to the lower bound of CQC's advised estimated value excluding VAT of "between 1,800,000 and 2,300,000 GBP"[1]

Full costs

Detailed costs are included in the remaining pages of this document.

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Schedule 4

Responsibilities & Contract Management

CLIENT'S RESPONSIBILITIES

CQC's Survey Team will:

- appoint a person to manage the contract and act as a primary contact for all contractual matters.
- set the strategic direction for the collection of survey and feedback information and will set individual requirements for the number of packages in each lot.
- set the packages of work and the timescales relevant to each package.
- provide an identified contact for each work package.
- develop and communicate any quality assurance requirements to ensure that all tools and services are delivered to a high standard.

CONTRACTOR RESPONSIBILITIES

The Co-ordination Centre must:

- appoint a person to manage the contract with CQC and act as the main point of contact for any queries in relation to the management or monitoring of the contract. This will include performance against any key performance indicators as set out below.
- provide the secretariat for an appropriate steering group established by CQC to support the development and delivery of any survey.
- provide CQC with a fortnightly written progress report. The report must provide sufficient detail for CQC to understand progress, next steps and any changes to the timescale. The update should link clearly to the timetables for all work (see section 6) so that CQC is able to track progress against planned actions.

- chair a liaison meeting with the manager of CQC's Survey Team at least monthly. This will be a high level meeting to discuss contract management, finance and progress. The meeting should provide sufficient information to understand current and planned progress, issues and risks to progress along with any planned mitigation, and progress against agreed timelines

- chair work package specific meetings at least quarterly to discuss all surveys and feedback. These meeting should provide sufficient information to understand current and planned progress, issues and risks to progress along with any planned mitigation, progress against agreed timelines and planned progress going forward.

- chair work package specific meetings at key points within the timetables of each package. These meetings will discuss the delivery of the work package and any specific issues and risks to that delivery.

- undertake evaluation and quality assurance on its work to provide CQC with sufficient assurance that its work meets required quality standards and learns from experience.

- provide a monthly update on costs and invoicing based on the packages of work that it has been requested to undertake.

- Report to CQC any potential slippage in established timelines for agreement and any risks or issues that may impact on the work in a timely manner and no later than the next senior liaison meeting.

- Maintain an up to date IG tool kit to a standard set by CQC or the Confidentiality Advisory Group. Where scores fall below 100% an action plan must be submitted to CQC detailing how scores will be improved before the next assessment. Each Approved Contractor must also be listed on the Data protection register for the purposes of research and adhere to all conditions and agreements made between the CAG and CQC.

CONTRACT MANAGEMENT AND MONITORING

The key personnel involved in the management of this contract will be as follows:

Client Service/Contract Manager

This role will be undertaken by the Authority's Survey's Lead. They will be responsible for day-to-day service management issues, monitoring delivery against agreed project plans and acting as the first point of escalation for any issues/risks.

Client's Senior Responsible Officer

The Authority's Director of Intelligence will be the Senior Responsible Officer (SRO) for this contract. They will be the senior supplier and relationship manager for the Client and the secondary point of escalation for service related issues.

Client Commercial Contracts Lead

The Authority's Senior Contracts Advisor will be the primary contact for any commercial matters or contractual issues/disputes.

The successful Tenderer will be expected to attend the following meetings:

Meeting Title & Frequency	Purpose
Operational Delivery Meeting - Weekly	To discuss and review the delivery of day-to-day services. Review progress against project plan. Discuss and review risks and issues. Review any complaints, feedback and corrective actions undertaken. Discuss invoicing and payment. Review contract and service provision.
Performance Review Meeting - Monthly	Review overall supplier and contract performance, including compliance and achievement of KPI's. Review spend figures (quarterly & year to date). Discuss and review potential improvements, opportunities and innovation. Review activity required in next quarter and any emerging challenges. This will include signing off inspection plans for the next quarter.
Operational Delivery Meeting -	To discuss all surveys and feedback specific packages. These meeting should provide sufficient information to understand current and planned progress, issues and risks to

Quarterly	progress along with any planned mitigation, progress against agreed timelines and planned progress going forward.
Service and Contract Review Meeting - Annual	Review overall contract and supplier performance across the period. Discuss success of contract in meeting business requirements. Review challenges and emerging themes.

Schedule 5

Commercially Sensitive Information

There is now a Government requirement regarding transparency and visibility of central government procurement activities (tenders & contracts) to the public. All contracts over 10k must now be published on a single website, can you please advise me if there is any sensitive information within the contract that you do not wish to be published on "Contracts Finder", or alternatively please send me back a redacted version.

Schedule 6

Key Performance Indicators

The successful Tenderer will be expected to deliver services in line with the Key Performance Indicator's (KPI's) outlined below. These are the minimum key performance indicators which will be used to measure the success of this Contract.

The Client reserves the right to use the performance data associated with this as a means to measure contract and supplier performance and these will be used to determine contract remedy to be applied.

Performance will be score on a points system, with a failure to meet critical KPI's (3 points) and non-critical (1 point). If a breach of 3 points or more is made over two consecutive months then the supplier will be in breach of contract and remedy applied. This breach can be made up of either 1 critical breach or a number of non-critical breaches or a mixture of the two.

These will be determined via a mechanism of "requires action" and or "contract action notices".

All reports showing adherence to Key Performance Indicators and Management Information is to be sent to the Authority's Contract & Service Manager in line with the timings outlined below.

No	Key Performance Indicator	Threshold
1	**Delivery of Survey & Feedback outputs** The Tenderer is required to deliver survey & feedback outputs for each of the defined work packages, in line with CQC's guidance, instructions or commissioning notes for any work package.	100% Critical KPI
2	**Resource mobilisation in line with survey programme requirements profile** The Contractor is required to ensure that there is sufficient personnel and other resources to deliver the work packages on time and to the quality standards required.	95% Critical KPI
3	**Attendance at Meetings** The Contractor is required to attend all planned Operational Delivery (as outlined in Contractor Responsibilities), Performance Review and Annual Review meetings, unless otherwise agreed with the Authority	97% Critical KPI

4	**Availability of Contractor** The Contractor will be contactable to the Client between the hours of 9am to 5pm Monday to Friday (excluding Bank Holidays) The Contractor is required to respond to all general queries within 24 hours. Simple queries should be resolved within 48 hours. Complex queries should be resolved within 5 days.	95% Critical KPI 95%Non-critical KPI 95% Non-critical KPI 95% Non-critical KPI
5	**Security Requirements** Services will be delivered in accordance with information security, data protection any confidentiality requirements including those agreed with the Confidential Advisory Group (CAG). The Co-ordination centre will advise CQC where any such breach occurs.	100% Critical KPI
6	**Delivery Timescales** Services will be delivered in accordance with agreed timelines and any change is raised and agreed by a member of CQC's Survey Team. Progress will outlined at fortnightly progress reports and monthly meeting.	95% Critical KPI
7	**Evaluation and learning** Evaluation and learning will be completed at the end of each delivered package, and any identified improvements flagged along with an action plan for development.	95% Non-critical KPI
8	**Quality of Expertise** The Contractor is to ensure that individuals providing support to the survey programme are those stated in the response or an equivalently qualified individual where the stated personnel have left the Co-ordination Centre.	100% Critical KPI
9	**Quality Assurance Framework** The Contractor is required to deliver survey & feedback outputs in line with the approved quality standards. This must include that all work will be quality assured and suitable assurance provided to CQC identifying what checks are in place and how and when they have been undertaken and by who.	98% Critical KPI

Schedule 7

Exit Management Strategy

Schedule 8

Business Continuity and Disaster Recovery Plan

Schedule 9

Form of Contract Change Notice

Contract Change Note Number **Contract Reference Number & Title** **Variation Title** **Number of Pages**	

WHEREAS the Contractor and the Client entered into a Contract for the supply of [project name] dated [dd/mm/yyyy] (the "Original Contract") and now wish to amend the Original Contract

IT IS AGREED as follows

1. The Original Contract shall be amended as set out in this Change Control Notice:

Change Requestor / Originator		
Summary of Change		
Reason for Change		
Revised Contract Price	Original Contract Value	£
	Previous Contract Changes	£
	Contract Change Note [x]	£
	New Contract Value	£
Revised Payment Schedule		
Revised Specification (See Annex [x] for Details)		
Revised Contract Period		
Change in Contract Manager(s)		
Other Changes		

2. Save as herein amended all other terms of the Original Contract shall remain effective.