



Using information on quality to make decisions about services

A systematic review reported that people with long-term conditions or disabilities and their families sought information on the quality of health and social care services from multiple sources, in particular social networks. These groups tended to use general or subjective information rather than formal quality indicators to make decisions about providers.

Quality

- Excellent
- Very good
- Good
- Fair
- Poor



Overview: Offering people choice in who provides their health or social care has been shown to improve service quality and lead to better health outcomes ([Cooper et al. 2011](#)). In England, the [Health and Social Care Act 2012](#) enshrined in law the requirement for NHS organisations to protect and promote the right of patients to make choices about treatment or other healthcare services. The [NHS Choice Framework](#) outlines the circumstances where people have a legal right to choose their treatment and care in the NHS. In addition, [personal budgets](#) from local authorities

allow people to choose how they would like to receive social care and support.

Information on the quality, cost and availability of services is important to allow people to make decisions about health or social care. However, patients may have limited awareness of information on the quality of services and may not use such information in making decisions ([Ketelaar et al. 2011](#)).

Current advice: The NICE guideline on [patient experience in adult NHS services](#) recommends that patients, and their family members and/or carers where appropriate, should be given information, and the support they need to make use of the information, in order to promote their active participation in care and self-management.

Support should be offered to patients who are considering their diagnosis, prognosis and treatment options. The principles of shared decision making should be used, including ensuring that the patient is aware of the options available and the risks, benefits and consequences of these. Whether or not the patient understands the information should be clarified.

The NICE guideline on medicines optimisation recommends that many people wish to be active participants in their own healthcare, and to be involved in making decisions about their medicines. Patient decision aids can ensure that patients, and their family members or carers where appropriate,

are able to make well-informed choices. The best available evidence should be used when making decisions with or for individuals.

The NICE pathways on [patient experience in adult NHS services](#) and [medicines optimisation](#) bring together all related NICE guidance and associated products in sets of interactive topic-based diagrams.

New evidence: [Turnpenny and Beadle-Brown \(2015\)](#) did a systematic review of evidence on how people with long-term conditions or disabilities and their families used information about service quality to make decisions about health and social care providers. Of the 13 studies included, 5 considered decision-making in healthcare, such as choosing a facility for elective orthopaedic surgery, and 7 considered decisions about social care, such as selecting a nursing home (1 study assessed both health and social care). The information available included formal quality reports (for example, inspection reports), information about the characteristics of a service or provider (for example, number and qualifications of staff) and informal reports about quality (for example, personal experience).

The review found that people with long-term conditions or disabilities used a wide variety of sources for information on the quality of health and social care; for example, advertising, information from service providers, and the internet. Medical professionals and informal networks were trusted as sources of information on quality. However, people generally had very little awareness of formal sources of information about quality, such as inspection reports, and very limited knowledge about indicators of a quality service.

When the type of information on quality was considered, written information presented as percentages and graphs was valued, as was verbal information. Consumer satisfaction was found to be an important type of information on quality, followed by inspection reports and formal quality indicators. Experiential and subjective information (such as user ratings) was highly valued and trusted.

People who used information on quality applied it in a variety of ways determined by their personal circumstances: some used personal key indicators, others considered all indicators, and some used exclusion criteria. However, decision-making on health and social care providers was often based on general information (such as location) or subjective impressions (such as perceived reputation). People tended to use their own definition of quality, such as friendliness of staff or cleanliness, when formal information was lacking or when quality information was difficult to interpret.

A limitation of this review is that studies in countries other than the UK were included, and differences in the organisation of health and social care in different countries could have influenced the findings. In addition, few details were given of the search strategy, secondary studies and grey literature were not included, and publication bias was not assessed.

Commentary: “This is a well-executed systematic review that addresses access and use of ‘quality information’ by people with long-term conditions and their families. The findings appear robust, if not that surprising – that is, that people use multiple sources of information on quality and rely more on general information and personal networks than ‘official’ sources. However, the evidence adds to our understanding of why certain sources are not used, in particular highlighting the importance of trust and timeliness.

“The evidence usefully highlights the challenges that service users face, especially when under time pressure, in appropriating ‘official’ information on quality so that they can actually use it to inform their personal decisions. This finding is important because it suggests that no matter how robust formalised quality information is, there will still be challenges of use. This information is necessarily generic, speaking to populations rather than individuals. This study suggests that achieving the benefits of choice requires not just more and improved sources of information, but more effective means, beyond just personal networks, to help people with long-term conditions and their families translate information on quality so that it is appropriate for their personal circumstances. Improving professional

support aimed at helping service users actually use, rather than just access, quality information may reduce the transition and psychological costs associated with ill-informed choices.

“The review has some limitations that, while acknowledged, could be further addressed. It includes studies from countries (UK, USA and Netherlands) that have very different health systems. The authors could have considered some analysis of whether there were country differences in the reporting of findings or whether contextual contingencies were noted in these studies. Finally the definition of ‘quality information’ is very broad, including sources (for example, personal appraisal of the décor and furnishing of care homes) that might arguably relate to things other than quality of care.” – **Professor Jacky Swan, Professor in Organisational Behaviour, University of Warwick**

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About this article: This article appeared in the July 2015 issue of the [Eyes on Evidence newsletter](#). This free monthly newsletter from NICE Evidence Services outlines interesting new evidence and what it means for current practice. The articles do not constitute formal NICE guidance. The commentaries included are the opinions of contributors and do not necessarily reflect the views of NICE.

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