INPATIENT QUESTIONNAIRE

What is the survey about?

This survey is about your **most recent** experience as an **inpatient** at the National Health Service hospital named in the letter enclosed with this questionnaire.

Who should complete the questionnaire?

The questions should be answered by the person named on the front of the envelope. If that person needs help to complete the questionnaire, the answers should be given from his/her point of view – not the point of view of the person who is helping.

Completing the questionnaire

For each question please tick clearly inside one box using a black or blue pen.

Sometimes you will find the box you have ticked has an instruction to go to another question. By following the instructions carefully you will miss out questions that do not apply to you.

Don't worry if you make a mistake; simply cross out the mistake and put a tick in the correct box.

Please **do not** write your name or address anywhere on the questionnaire.

Questions or help?

If you have any queries about the questionnaire, please call the helpline number given in the letter enclosed with this questionnaire.

Your participation in this survey is voluntary. **Your answers will be treated in confidence.**

Copyright 2003. Picker Institute Europe. All rights reserved.

Please remember, this questionnaire is about your **most recent** stay at the hospital named in the accompanying letter.

ADMISSION TO HOSPITAL

1. Was your hospital stay planned in advance or an emergency?

1 ☐ Emergency/dialled 999/immediately referred by GP or NHS direct ➔ **Go to 2**

2 ☐ Waiting list or planned in advance ➔ **Go to 4**

3 ☐ Something else ➔ **Go to 4**

Emergency or immediately referred

2. How organised was the **care** you received in Accident & Emergency (or the Medical Admissions Unit)?

1 ☐ Not at all organised

2 ☐ Fairly organised

3 ☐ Very organised

3. Following arrival at the hospital, how long did you wait before admission to a room or ward and bed?

1 ☐ Less than 1 hour

2 ☐ At least 1 hour but less than 2 hours

3 ☐ At least 2 hours but less than 4 hours

4 ☐ At least 4 hours but less than 8 hours

5 ☐ 8 hours or longer

6 ☐ Can't remember

7 ☐ I did not have to wait

➔ **Now please go to Question 9 on next page**

Waiting list or planned admission

4. How do you feel about the length of time you were on the waiting list before your admission to hospital?

1 ☐ I was admitted as soon as I thought was necessary

2 ☐ I should have been admitted a bit sooner

3 ☐ I should have been admitted a lot sooner

5. When you were told you would be going into hospital, were you given enough notice of your date of admission?

1 ☐ Yes, enough notice

2 ☐ No, not enough notice

6. Were you given a choice of admission date?

1 ☐ Yes

2 ☐ No

3 ☐ Don't know/ Can't remember

7. Was your admission date changed by the hospital?

1 ☐ No

2 ☐ Yes, once

3 ☐ Yes, 2 or 3 times

4 ☐ Yes, 4 times or more

8. Were you given a choice about **which hospital** you were admitted to?

1 ☐ Yes

2 ☐ No

3 ☐ Don't know/ Can't remember

Copyright 2003. Picker Institute Europe. All rights reserved.

All types of admission

9. From the time you arrived at the hospital, did you feel that you had to wait a long time to get to a bed on a ward?

1 ☐ Yes, definitely

2 ☐ Yes, to some extent

3 ☐ No

THE HOSPITAL AND WARD

10. During your stay in hospital, did you ever share a room or bay with patients of the opposite sex?

1 ☐ Yes

2 ☐ No

11. Were you ever bothered by noise at night from **other patients**?

1 ☐ Yes

2 ☐ No

12. Were you ever bothered by noise at night from **hospital staff**?

1 ☐ Yes

2 ☐ No

13. In your opinion, how clean was the hospital room or ward that you were in?

1 ☐ Very clean

2 ☐ Fairly clean

3 ☐ Not very clean

4 ☐ Not at all clean

14. How clean were the toilets and bathrooms that you used in hospital?

1 ☐ Very clean

2 ☐ Fairly clean

3 ☐ Not very clean

4 ☐ Not at all clean

5 ☐ I did not use a toilet or bathroom

15. How would you rate the hospital food?

1 ☐ Very good

2 ☐ Good

3 ☐ Fair

4 ☐ Poor

5 ☐ I did not have any hospital food

DOCTORS

16. When you had important questions to ask a doctor, did you get answers that you could understand?

1 ☐ Yes, always

2 ☐ Yes, sometimes

3 ☐ No

4 ☐ I had no need to ask

17. Did you have confidence and trust in the doctors treating you?

1 ☐ Yes, always

2 ☐ Yes, sometimes

3 ☐ No

Copyright 2003. Picker Institute Europe. All rights reserved.

18. Did doctors talk in front of you as if you weren't there?

1 ☐ Yes, often

2 ☐ Yes, sometimes

3 ☐ No

NURSES

19. When you had important questions to ask a nurse, did you get answers that you could understand?

1 ☐ Yes, always

2 ☐ Yes, sometimes

3 ☐ No

4 ☐ I had no need to ask

20. Did you have confidence and trust in the nurses treating you?

1 ☐ Yes, always

2 ☐ Yes, sometimes

3 ☐ No

21. Did nurses talk in front of you as if you weren't there?

1 ☐ Yes, often

2 ☐ Yes, sometimes

3 ☐ No

22. In your opinion, were there enough nurses on duty to care for you in hospital?

1 ☐ There were always or nearly always enough nurses

2 ☐ There were sometimes enough nurses

3 ☐ There were rarely or never enough nurses

YOUR CARE AND TREATMENT

23. Sometimes in a hospital, a member of staff will say one thing and another will say something quite different. Did this happen to you?

1 ☐ Yes, often

2 ☐ Yes, sometimes

3 ☐ No

24. Were you involved as much as you wanted to be in decisions about your care and treatment?

1 ☐ Yes, definitely

2 ☐ Yes, to some extent

3 ☐ No

25. How much information about your condition or treatment was given to **you**?

1 ☐ Not enough

2 ☐ The right amount

3 ☐ Too much

26. If your family or someone else close to you wanted to talk to a doctor, did they have enough opportunity to do so?

1 ☐ Yes, definitely

2 ☐ Yes, to some extent

3 ☐ No

4 ☐ No family or friends were involved

5 ☐ My family did not want or need information

6 ☐ I did not want my family or friends to talk to a doctor

Copyright 2003. Picker Institute Europe. All rights reserved.

27. Did you find someone on the hospital staff to talk to about your worries and fears?

1 ☐ Yes, definitely

2 ☐ Yes, to some extent

3 ☐ No

4 ☐ I had no worries or fears

28. Were you given enough privacy when discussing your condition or treatment?

1 ☐ Yes, always

2 ☐ Yes, sometimes

3 ☐ No

29. Were you given enough privacy when being examined or treated?

1 ☐ Yes, always

2 ☐ Yes, sometimes

3 ☐ No

30. How many minutes after you used the call button did it usually take before you got the help you needed?

1 ☐ 0 minutes/right away

2 ☐ 1-2 minutes

3 ☐ 3-5 minutes

4 ☐ More than 5 minutes

5 ☐ I never got help when I used the call button

6 ☐ I never used the call button

31. During your stay in hospital, did you have any tests, x-rays or scans other than blood or urine tests?

1 ☐ Yes ➔ **Go to 32**

2 ☐ No ➔ **Go to 33**

32. Were your scheduled tests, x-rays or scans performed on time?

1 ☐ Yes, always

2 ☐ Yes, sometimes

3 ☐ No

PAIN

33. Were you ever in any pain?

1 ☐ Yes ➔ **Go to 34**

2 ☐ No ➔ **Go to 35**

34. Do you think the hospital staff did everything they could to help control your pain?

1 ☐ Yes, definitely

2 ☐ Yes, to some extent

3 ☐ No

Copyright 2003. Picker Institute Europe. All rights reserved.

LEAVING HOSPITAL

35. On the day you left hospital, was your discharge delayed for any reason?

1 ☐ Yes ➔ **Go to 36**

2 ☐ No ➔ **Go to 38**

36. What was the **main** reason for the delay? **(Tick ONE only)**

1 ☐ I had to wait for **medicines**

2 ☐ I had to wait to **see the doctor**

3 ☐ I had to wait for an **ambulance**

4 ☐ Something else

37. How long was the delay?

1 ☐ Up to 1 hour

2 ☐ Longer than 1 hour but no longer than 2 hours

3 ☐ Longer than 2 hours but no longer than 4 hours

4 ☐ Longer than 4 hours

38. Did a member of staff explain the purpose of the medicines you were to take at home in a way you could understand?

1 ☐ Yes, completely ➔ **Go to 39**

2 ☐ Yes, to some extent ➔ **Go to 39**

3 ☐ No ➔ **Go to 39**

4 ☐ I did not need an explanation ➔ **Go to 39**

5 ☐ I had no medicines ➔ **Go to 40**

39. Did a member of staff tell you about medication side effects to watch for when you went home?

1 ☐ Yes, completely

2 ☐ Yes, to some extent

3 ☐ No

4 ☐ I did not need an explanation

40. Did a member of staff tell you about any danger signals you should watch for after you went home?

1 ☐ Yes, completely

2 ☐ Yes, to some extent

3 ☐ No

4 ☐ It was not necessary

41. Did the doctors or nurses give your family or someone close to you all the information they needed to help you recover?

1 ☐ Yes, definitely

2 ☐ Yes, to some extent

3 ☐ No

4 ☐ No family or friends were involved

5 ☐ My family or friends did not want or need information

42. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?

1 ☐ Yes

2 ☐ No

3 ☐ Don't know / Can't remember

Copyright 2003. Picker Institute Europe. All rights reserved.

OVERALL

43. Overall, did you feel you were treated with respect and dignity while you were in the hospital?

1 ☐ Yes, always

2 ☐ Yes, sometimes

3 ☐ No

44. How would you rate how well the doctors and nurses worked together?

1 ☐ Excellent

2 ☐ Very good

3 ☐ Good

4 ☐ Fair

5 ☐ Poor

45. Overall, how would you rate the care you received?

1 ☐ Excellent

2 ☐ Very good

3 ☐ Good

4 ☐ Fair

5 ☐ Poor

ABOUT YOU

46. Are you male or female?

1 ☐ Male

2 ☐ Female

47. What was your year of birth?

(Please write in) e.g. | 1 | 9 | 3 | 4 |

48. How old were you when you left full-time education?

1 ☐ 16 years or less

2 ☐ 17 or 18 years

3 ☐ 19 years or over

4 ☐ Still in full-time education

49. Overall, how would you rate your health during the **past 4 weeks**?

1 ☐ Excellent

2 ☐ Very good

3 ☐ Good

4 ☐ Fair

5 ☐ Poor

6 ☐ Very poor

Copyright 2003. Picker Institute Europe. All rights reserved.

50. To which of these ethnic groups would you say you belong? (**Tick ONE only**)

a. WHITE

1 ☐ British

2 ☐ Irish

3 ☐ Any other White background
(Please write in box)

b. MIXED

4 ☐ White and Black Caribbean

5 ☐ White and Black African

6 ☐ White and Asian

7 ☐ Any other Mixed background
(Please write in box)

c. ASIAN OR ASIAN BRITISH

8 ☐ Indian

9 ☐ Pakistani

10 ☐ Bangladeshi

11 ☐ Any other Asian background
(Please write in box)

d. BLACK OR BLACK BRITISH

12 ☐ Caribbean

13 ☐ African

14 ☐ Any other Black background
(Please write in box)

e. CHINESE OR OTHER ETHNIC GROUP

15 ☐ Chinese

16 ☐ Any other ethnic group
(Please write in box)

OTHER COMMENTS

If there is anything else you would like to tell us about your experiences in the hospital, please do so here.

Was there anything particularly good about your hospital care?

Was there anything that could be improved?

Any other comments?

THANK YOU VERY MUCH FOR YOUR HELP

Please check that you answered all the questions that apply to you.

Please post this questionnaire back in the FREEPOST envelope provided.

No stamp is needed.

Copyright 2003. Picker Institute Europe. All rights reserved.

INPATIENT QUESTIONNAIRE

What is the survey about?

This survey is about your **most recent** experience as an **inpatient** at the National Health Service hospital named in the letter enclosed with this questionnaire.

Who should complete the questionnaire?

The questions should be answered by the person named on the front of the envelope. If that person needs help to complete the questionnaire, the answers should be given from his/her point of view – not the point of view of the person who is helping.

Completing the questionnaire

For each question please tick clearly inside one box using a black or blue pen.

Sometimes you will find the box you have ticked has an instruction to go to another question. By following the instructions carefully you will miss out questions that do not apply to you.

Don't worry if you make a mistake; simply cross out the mistake and put a tick in the correct box.

Please **do not** write your name or address anywhere on the questionnaire.

Questions or help?

If you have any queries about the questionnaire, please call the helpline number given in the letter enclosed with this questionnaire.

Your participation in this survey is voluntary. **Your answers will be treated in confidence.**

Copyright 2003. Picker Institute Europe. All rights reserved.

Please remember, this questionnaire is about your **most recent** stay at the hospital named in the accompanying letter.

ADMISSION TO HOSPITAL

1. Was your hospital stay planned in advance or an emergency?

1 ☐ Emergency/dialled 999/immediately referred by GP or NHS direct ➔ **Go to** 2

2 ☐ Waiting list or planned in advance ➔ **Go to** 4

3 ☐ Something else ➔ **Go to** 4

Emergency or immediately referred

2. How organised was the **care** you received in Accident & Emergency (or the Medical Admissions Unit)?

0₁ ☐ Not at all organised

50₂ ☐ Fairly organised

100₃ ☐ Very organised

3. Following arrival at the hospital, how long did you wait before admission to a room or ward and bed?

100₁ ☐ Less than 1 hour

75₂ ☐ At least 1 hour but less than 2 hours

50₃ ☐ At least 2 hours but less than 4 hours

25 ₄☐ At least 4 hours but less than 8 hours

0₅ ☐ 8 hours or longer

_₆ ☐ Can't remember

_₇ ☐ I did not have to wait

➔ **Now please go to Question 9 on next page**

Waiting list or planned admission

4. How do you feel about the length of time you were on the waiting list before your admission to hospital?

100₁ ☐ I was admitted as soon as I thought was necessary

50₂ ☐ I should have been admitted a bit sooner

0₃ ☐ I should have been admitted a lot sooner

5. When you were told you would be going into hospital, were you given enough notice of your date of admission?

100₁ ☐ Yes, enough notice

0₂ ☐ No, not enough notice

6. Were you given a choice of admission date?

100₁ ☐ Yes

0₂ ☐ No

_₃ ☐ Don't know/ Can't remember

7. Was your admission date changed by the hospital?

100₁ ☐ No

67₂ ☐ Yes, once

33₃ ☐ Yes, 2 or 3 times

0₄ ☐ Yes, 4 times or more

8. Were you given a choice about **which hospital** you were admitted to?

100₁ ☐ Yes

0₂ ☐ No

_₃ ☐ Don't know/ Can't remember

Copyright 2003. Picker Institute Europe. All rights reserved.

All types of admission

9. From the time you arrived at the hospital, did you feel that you had to wait a long time to get to a bed on a ward?

0₁ ☐ Yes, definitely

50₂ ☐ Yes, to some extent

100₃ ☐ No

THE HOSPITAL AND WARD

10. During your stay in hospital, did you ever share a room or bay with patients of the opposite sex?

0₁ ☐ Yes

100₂ ☐ No

11. Were you ever bothered by noise at night from **other patients**?

0₁ ☐ Yes

100₂ ☐ No

12. Were you ever bothered by noise at night from **hospital staff**?

0₁ ☐ Yes

100₂ ☐ No

13. In your opinion, how clean was the hospital room or ward that you were in?

100₁ ☐ Very clean

67₂ ☐ Fairly clean

33₃ ☐ Not very clean

0₄ ☐ Not at all clean

14. How clean were the toilets and bathrooms that you used in hospital?

100₁ ☐ Very clean

67₂ ☐ Fairly clean

33₃ ☐ Not very clean

0₄ ☐ Not at all clean

_₅ ☐ I did not use a toilet or bathroom

15. How would you rate the hospital food?

100₁ ☐ Very good

67₂ ☐ Good

33₃ ☐ Fair

0₄ ☐ Poor

_₅ ☐ I did not have any hospital food

DOCTORS

16. When you had important questions to ask a doctor, did you get answers that you could understand?

100₁ ☐ Yes, always

50₂ ☐ Yes, sometimes

0₃ ☐ No

_₄ ☐ I had no need to ask

17. Did you have confidence and trust in the doctors treating you?

100₁ ☐ Yes, always

50₂ ☐ Yes, sometimes

0 ₃ ☐ No

Copyright 2003. Picker Institute Europe. All rights reserved.

18. Did doctors talk in front of you as if you weren't there?

0₁ ☐ Yes, often

50₂ ☐ Yes, sometimes

100 ₃ ☐ No

NURSES

19. When you had important questions to ask a nurse, did you get answers that you could understand?

100₁ ☐ Yes, always

50₂ ☐ Yes, sometimes

0₃ ☐ No

-₄ ☐ I had no need to ask

20. Did you have confidence and trust in the nurses treating you?

100₁ ☐ Yes, always

50₂ ☐ Yes, sometimes

0 ₃ ☐ No

21. Did nurses talk in front of you as if you weren't there?

0₁ ☐ Yes, often

50₂ ☐ Yes, sometimes

100 ₃ ☐ No

22. In your opinion, were there enough nurses on duty to care for you in hospital?

100₁ ☐ There were always or nearly always enough nurses

50₂ ☐ There were sometimes enough nurses

0₃ ☐ There were rarely or never enough nurses

YOUR CARE AND TREATMENT

23. Sometimes in a hospital, a member of staff will say one thing and another will say something quite different. Did this happen to you?

0₁ ☐ Yes, often

50₂ ☐ Yes, sometimes

100₃ ☐ No

24. Were you involved as much as you wanted to be in decisions about your care and treatment?

100₁ ☐ Yes, definitely

50₂ ☐ Yes, to some extent

0₃ ☐ No

25. How much information about your condition or treatment was given to **you**?

0₁ ☐ Not enough

100₂ ☐ The right amount

0₃ ☐ Too much

26. If your family or someone else close to you wanted to talk to a doctor, did they have enough opportunity to do so?

100₁ ☐ Yes, definitely

50₂ ☐ Yes, to some extent

0₃ ☐ No

_₄ ☐ No family or friends were involved

_₅ ☐ My family did not want or need information

_₆ ☐ I did not want my family or friends to talk to a doctor

Copyright 2003. Picker Institute Europe. All rights reserved.

27. Did you find someone on the hospital staff to talk to about your worries and fears?

100₁ ☐ Yes, definitely

50₂ ☐ Yes, to some extent

0₃ ☐ No

_₄ ☐ I had no worries or fears

28. Were you given enough privacy when discussing your condition or treatment?

100₁ ☐ Yes, always

50₂ ☐ Yes, sometimes

0₃ ☐ No

29. Were you given enough privacy when being examined or treated?

100₁ ☐ Yes, always

50₂ ☐ Yes, sometimes

0₃ ☐ No

30. How many minutes after you used the call button did it usually take before you got the help you needed?

100₁ ☐ 0 minutes/right away

75₂ ☐ 1-2 minutes

50₃ ☐ 3-5 minutes

25₄ ☐ More than 5 minutes

0₅ ☐ I never got help when I used the call button

-₆ ☐ I never used the call button

31. During your stay in hospital, did you have any tests, x-rays or scans other than blood or urine tests?

₁ ☐ Yes ➔ **Go to 32**

₂ ☐ No ➔ **Go to 33**

32. Were your scheduled tests, x-rays or scans performed on time?

100₁ ☐ Yes, always

50₂ ☐ Yes, sometimes

0₃ ☐ No

PAIN

33. Were you ever in any pain?

₁ ☐ Yes ➔ **Go to 34**

₂ ☐ No ➔ **Go to 35**

34. Do you think the hospital staff did everything they could to help control your pain?

100₁ ☐ Yes, definitely

50₂ ☐ Yes, to some extent

0₃ ☐ No

Copyright 2003. Picker Institute Europe. All rights reserved.

LEAVING HOSPITAL

35. On the day you left hospital, was your discharge delayed for any reason?

- 1 ☐ Yes ➔ **Go to 36**

100 2 ☐ No ➔ **Go to 38**

36. What was the **main** reason for the delay? **(Tick ONE only)**

1 ☐ I had to wait for **medicines**

2 ☐ I had to wait to **see the doctor**

3 ☐ I had to wait for an **ambulance**

4 ☐ Something else

37. How long was the delay?

75 1 ☐ Up to 1 hour

50 2 ☐ Longer than 1 hour but no longer than 2 hours

25 3 ☐ Longer than 2 hours but no longer than 4 hours

0 4 ☐ Longer than 4 hours

38. Did a member of staff explain the purpose of the medicines you were to take at home in a way you could understand?

100 1 ☐ Yes, completely ➔ **Go to 39**

50 2 ☐ Yes, to some extent ➔ **Go to 39**

0 3 ☐ No ➔ **Go to 39**

- 4 ☐ I did not need an explanation ➔ **Go to 39**

- 5 ☐ I had no medicines ➔ **Go to 40**

39. Did a member of staff tell you about medication side effects to watch for when you went home?

100 1 ☐ Yes, completely

50 2 ☐ Yes, to some extent

0 3 ☐ No

_ 4 ☐ I did not need an explanation

40. Did a member of staff tell you about any danger signals you should watch for after you went home?

100 1 ☐ Yes, completely

50 2 ☐ Yes, to some extent

0 3 ☐ No

_ 4 ☐ It was not necessary

41. Did the doctors or nurses give your family or someone close to you all the information they needed to help you recover?

100 1 ☐ Yes, definitely

50 2 ☐ Yes, to some extent

0 3 ☐ No

_ 4 ☐ No family or friends were involved

_ 5 ☐ My family or friends did not want or need information

42. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?

100 1 ☐ Yes

0 2 ☐ No

_ 3 ☐ Don't know / Can't remember

Copyright 2003. Picker Institute Europe. All rights reserved.

OVERALL

43. Overall, did you feel you were treated with respect and dignity while you were in the hospital?

100 1 ☐ Yes, always

50 2 ☐ Yes, sometimes

0 3 ☐ No

44. How would you rate how well the doctors and nurses worked together?

100 1 ☐ Excellent

75 2 ☐ Very good

50 3 ☐ Good

25 4 ☐ Fair

0 5 ☐ Poor

45. Overall, how would you rate the care you received?

100 1 ☐ Excellent

75 2 ☐ Very good

50 3 ☐ Good

25 4 ☐ Fair

0 5 ☐ Poor

ABOUT YOU

46. Are you male or female?

1 ☐ Male

2 ☐ Female

47. What was your year of birth?

(Please write in) e.g. | 1 | 9 | 3 | 4 |

48. How old were you when you left full-time education?

1 ☐ 16 years or less

2 ☐ 17 or 18 years

3 ☐ 19 years or over

4 ☐ Still in full-time education

49. Overall, how would you rate your health during the **past 4 weeks**?

1 ☐ Excellent

2 ☐ Very good

3 ☐ Good

4 ☐ Fair

5 ☐ Poor

6 ☐ Very poor

Copyright 2003. Picker Institute Europe. All rights reserved.

50. To which of these ethnic groups would you say you belong? (**Tick ONE only**)

a. WHITE

1 ☐ British

2 ☐ Irish

3 ☐ Any other White background
(Please write in box)

b. MIXED

4 ☐ White and Black Caribbean

5 ☐ White and Black African

6 ☐ White and Asian

7 ☐ Any other Mixed background
(Please write in box)

c. ASIAN OR ASIAN BRITISH

8 ☐ Indian

9 ☐ Pakistani

10 ☐ Bangladeshi

11 ☐ Any other Asian background
(Please write in box)

d. BLACK OR BLACK BRITISH

12 ☐ Caribbean

13 ☐ African

14 ☐ Any other Black background
(Please write in box)

e. CHINESE OR OTHER ETHNIC GROUP

15 ☐ Chinese

16 ☐ Any other ethnic group
(Please write in box)

OTHER COMMENTS

If there is anything else you would like to tell us about your experiences in the hospital, please do so here.

Was there anything particularly good about your hospital care?

Was there anything that could be improved?

Any other comments?

THANK YOU VERY MUCH FOR YOUR HELP

Please check that you answered all the questions that apply to you.

Please post this questionnaire back in the FREEPOST envelope provided.

No stamp is needed.

Copyright 2003. Picker Institute Europe. All rights reserved.

Non survey variable definitions: In Patient 2004 survey data

1. trustcod Trust code (please see table 1 or trust list_in patient (04).xls for the name of trusts)
2. trustnum: Trust number
3. record: Patient record number
4. Day Day of discharge
5. Month Month of discharge
6. Year Year of discharge
7. outcome: Outcome of sending questionnaire
    - Returned useable questionnaire=1
    - Returned undelivered or pt moved house=2
    - Service user dies=3
    - Patient reported too ill to complete questionnaire=4
    - Patient was not eligible to fill in questionnaire=5
    - Questionnaire not returned - reason not known=6
8. birth Year of birth from trusts' administrative systems (where available, it may be preferable to use self reported year of birth, question 47)
9. gender: Gender, taken from the trusts' administrative systems, where available it may be preferable to use self reported gender instead (question 46
    - Male=1
    - Female=2

10. Ethnic: ethnic group from sample information
    - White-1
    - Mixed-2
    - Asian/Asian British-3
    - Black/Black British-4
    - Chineese-5
    - Any other ethnic group-6

Comp_age Age computed by q47 where available or from trust administrative data (birth)

Table 1. Name and number of trusts

Trust code	Trust name
RGT	Addenbrooke's NHS Trust
REM	Aintree Hospitals NHS Trust
RCF	Airedale NHS Trust
RTK	Ashford and St Peter's Hospitals NHS Trust
RF4	Barking, Havering and Redbridge Hospitals NHS Trust
RVL	Barnet and Chase Farm Hospitals NHS Trust
RFF	Barnsley District General Hospital NHS Trust
RNJ	Barts and The London NHS Trust
RDD	Basildon and Thurrock University Hospitals NHS Trust
RC1	Bedford Hospitals NHS Trust
RR1	Birmingham Heartlands and Solihull (Teaching) NHS Trust
RLU	Birmingham Women's Health Care NHS Trust
RXL	Blackpool, Fylde and Wyre Hospitals NHS Trust
RMC	Bolton Hospitals NHS Trust
RAE	Bradford Teaching Hospitals NHS Trust
RXH	Brighton and Sussex University Hospitals NHS Trust
RG3	Bromley Hospitals NHS Trust
RXQ	Buckinghamshire Hospitals NHS Trust
RJF	Burton Hospitals NHS Trust
RWY	Calderdale and Huddersfield NHS Trust
RW3	Central Manchester and Manchester Children's University Hospitals NHS Trust
RQM	Chelsea and Westminster Healthcare NHS Trust
RFS	Chesterfield and North Derbyshire Royal Hospital NHS Trust
RBV	Christie Hospital NHS Trust
RLN	City Hospitals Sunderland NHS Trust
REN	Clatterbridge Centre For Oncology NHS Trust
RJR	Countess Of Chester Hospital NHS Trust
RXP	County Durham and Darlington Acute Hospitals NHS Trust *
RN7	Dartford and Gravesham NHS Trust
RP5	Doncaster and Bassetlaw Hospitals NHS Trust
RNA	Dudley Group Of Hospitals NHS Trust
RC3	Ealing Hospital NHS Trust
RWH	East and North Hertfordshire NHS Trust
RJN	East Cheshire NHS Trust
RVV	East Kent Hospitals NHS Trust
RXR	East Lancashire Hospitals NHS Trust
RA4	East Somerset NHS Trust
RXC	East Sussex Hospitals NHS Trust
RVR	**Epsom and St Helier University Hospitals NHS Trust**
RDE	Essex Rivers Healthcare NHS Trust
RDU	Frimley Park Hospital NHS Trust
RR7	Gateshead Health NHS Trust
RLT	George Eliot Hospital NHS Trust
RTE	Gloucestershire Hospitals NHS Trust
RJH	Good Hope Hospital NHS Trust
RJ1	Guy's and St Thomas' NHS Trust
RQN	Hammersmith Hospitals NHS Trust
RCD	Harrogate Health Care NHS Trust
RD7	Heatherwood and Wexham Park Hospitals NHS Trust

RLQ Hereford Hospitals NHS Trust
RQQ Hinchingbrooke Health Care NHS Trust
RQX Homerton University Hospital NHS Trust
RWA Hull and East Yorkshire Hospitals NHS Trust
RGQ Ipswich Hospital NHS Trust
RR2 Isle Of Wight Healthcare NHS Trust
RGP James Paget Healthcare NHS Trust
RNQ Kettering General Hospital NHS Trust
RJZ King's College Hospital NHS Trust
RCX Kings Lynn and Wisbech Hospitals NHS Trust
RAX Kingston Hospital NHS Trust
RXN Lancashire Teaching Hospitals NHS Trust
RR8 Leeds Teaching Hospitals NHS Trust
REP Liverpool Womens Hospital NHS Trust
RC9 Luton and Dunstable Hospital NHS Trust
RWF Maidstone and Tunbridge Wells NHS Trust
RJ6 Mayday Healthcare NHS Trust
RPA Medway NHS Trust
RQ8 Mid Essex Hospital Services NHS Trust
RJD Mid Staffordshire General Hospitals NHS Trust
RXF Mid Yorkshire Hospitals NHS Trust
RD8 Milton Keynes General Hospital NHS Trust
RP6 Moorfields Eye Hospital NHS Trust
RTX Morecambe Bay Hospitals NHS Trust
RNH Newham Healthcare NHS Trust
RM1 Norfolk and Norwich University Hospital NHS Trust
RVJ North Bristol NHS Trust
RWW North Cheshire Hospitals NHS Trust
RNL North Cumbria Acute Hospitals NHS Trust
RN5 North Hampshire Hospitals NHS Trust
RAP North Middlesex University Hospital NHS Trust
RVW North Tees and Hartlepool NHS Trust
RV8 North West London Hospitals NHS Trust
RNS Northampton General Hospital NHS Trust
RBZ Northern Devon Healthcare NHS Trust
RJL Northern Lincolnshire and Goole Hospitals NHS Trust
RTF Northumbria Health Care NHS Trust
RCS Nottingham City Hospital NHS Trust
RBF Nuffield Orthopaedic NHS Trust
RTH Oxford Radcliffe Hospital NHS Trust
RGM Papworth Hospital NHS Trust
RW6 Pennine Acute Hospitals NHS Trust
RGN Peterborough Hospitals NHS Trust
RK9 Plymouth Hospitals NHS Trust
RD3 Poole Hospitals NHS Trust
RHU Portsmouth Hospitals NHS Trust
RG2 Queen Elizabeth Hospital NHS Trust
RGZ Queen Mary's Sidcup NHS Trust
RFK Queen's Medical Centre, Nottingham University Hospital NHS Trust
RL1 Robert Jones and Agnes Hunt Orthopaedic and District Hospital NHS Trust
RFR Rotherham General Hospitals NHS Trust
RHW Royal Berkshire and Battle Hospitals NHS Trust
RDZ Royal Bournemouth and Christchurch Hospitals NHS Trust
RT3 Royal Brompton and Harefield NHS Trust

REF Royal Cornwall Hospitals NHS Trust
RH8 Royal Devon and Exeter Healthcare NHS Trust
RAL Royal Free Hampstead NHS Trust
RQ6 Royal Liverpool and Broadgreen University Hospitals NHS Trust
RBB Royal National Hospital For Rheumatic Diseases NHS Trust
RRJ Royal Orthopaedic Hospital NHS Trust
RA2 Royal Surrey County Hospital NHS Trust
RD1 Royal United Hospital Bath NHS Trust
RPR Royal West Sussex NHS Trust
RM3 Salford Royal Hospitals NHS Trust
RNZ Salisbury Health Care NHS Trust
RXK Sandwell and West Birmingham Hospitals NHS Trust
RCC Scarborough and North East Yorkshire Health Care NHS Trust
RHQ Sheffield Teaching Hospitals NHS Trust
RK5 Sherwood Forest Hospitals NHS Trust
RXW Shrewsbury and Telford Hospitals NHS Trust
RA9 South Devon Health Care NHS Trust
RM2 South Manchester University Hospitals NHS Trust
RTR South Tees Hospitals NHS Trust
RE9 South Tyneside Health Care NHS Trust
RJC South Warwickshire General Hospitals NHS Trust
RHM Southampton University Hospitals NHS Trust
RAJ Southend Hospital NHS Trust
RTG Southern Derbyshire Acute Hospitals NHS Trust
RVY Southport and Ormskirk Hospital NHS Trust
RJ7 St George's Healthcare NHS Trust
RBN St Helens and Knowsley Hospitals NHS Trust
RJ5 St Mary's NHS Trust
RWJ Stockport NHS Trust
RTP Surrey and Sussex Healthcare NHS Trust
RN3 Swindon and Marlborough NHS Trust
RMP Tameside and Glossop Acute Services NHS Trust
RBA Taunton and Somerset NHS Trust
RBQ The Cardiothoracic Centre - Liverpool NHS Trust
RAS The Hillingdon Hospital NHS Trust
RJ2 The Lewisham Hospital NHS Trust
RBT The Mid Cheshire Hospitals NHS Trust
RTD The Newcastle Upon Tyne Hospitals NHS Trust
RQW The Princess Alexandra Hospital NHS Trust
RPC The Queen Victoria Hospital NHS Trust
RPY The Royal Marsden NHS Trust
RAN The Royal National Orthopaedic Hospital NHS Trust
RL4 The Royal Wolverhampton Hospitals NHS Trust
RKE The Whittington Hospital NHS Trust
RM4 Trafford Healthcare NHS Trust
RA7 United Bristol Healthcare NHS Trust
RWD United Lincolnshire Hospitals NHS Trust
RRV University College London Hospitals NHS Trust
RRK University Hospital Birmingham NHS Trust
RJE University Hospital Of North Staffordshire NHS Trust
RKB University Hospitals Coventry and Warwickshire NHS Trust
RWE University Hospitals Of Leicester NHS Trust
RBK Walsall Hospitals NHS Trust
RET Walton Centre For Neurology and Neurosurgery NHS Trust

RBD West Dorset General Hospitals NHS Trust
RWG West Hertfordshire Hospitals NHS Trust
RFW West Middlesex University NHS Trust
RGR West Suffolk Hospitals NHS Trust
RA3 Weston Area Health NHS Trust
RGC Whipps Cross University Hospital NHS Trust
RN1 Winchester and Eastleigh Healthcare NHS Trust
RBL Wirral Hospital NHS Trust
RWP Worcestershire Acute Hospitals NHS Trust
RPL Worthing and Southlands Hospitals NHS Trust
RRF Wrightington, Wigan and Leigh NHS Trust
RCB York Hospitals NHS Trust

Trust code	Trust name	SHA code	SHA name
RGT	Addenbrooke's NHS Trust	Q01	NORFOLK, SUFFOLK AND CAMBRIDGESHIRE STRATEGIC HA
REM	Aintree Hospitals NHS Trust	Q15	CHESHIRE & MERSEYSIDE STRATEGIC HA
RCF	Airedale NHS Trust	Q12	WEST YORKSHIRE STRATEGIC HA
RTK	Ashford and St Peter's Hospitals NHS Trust	Q19	SURREY AND SUSSEX STRATEGIC HA
RF4	Barking, Havering and Redbridge Hospitals NHS Trust	Q06	NORTH EAST LONDON STRATEGIC HA
RVL	Barnet and Chase Farm Hospitals NHS Trust	Q05	NORTH CENTRAL LONDON STRATEGIC HA
RFF	Barnsley District General Hospital NHS Trust	Q23	SOUTH YORKSHIRE STRATEGIC HA
RNJ	Barts and The London NHS Trust	Q06	NORTH EAST LONDON STRATEGIC HA
RDD	Basildon and Thurrock University Hospitals NHS Trust	Q03	ESSEX STRATEGIC HA
RC1	Bedford Hospitals NHS Trust	Q02	BEDFORDSHIRE AND HERTFORDSHIRE STRATEGIC HA
RR1	Birmingham Heartlands and Solihull (Teaching) NHS Trust	Q27	BIRMINGHAM AND THE BLACK COUNTRY STRATEGIC HA
RLU	Birmingham Women's Health Care NHS Trust	Q27	BIRMINGHAM AND THE BLACK COUNTRY STRATEGIC HA
RXL	Blackpool, Fylde and Wyre Hospitals NHS Trust	Q13	CUMBRIA AND LANCASHIRE STRATEGIC HA
RMC	Bolton Hospitals NHS Trust	Q14	GREATER MANCHESTER STRATEGIC HA
RAE	Bradford Teaching Hospitals NHS Trust	Q12	WEST YORKSHIRE STRATEGIC HA
RXH	Brighton and Sussex University Hospitals NHS Trust	Q19	SURREY AND SUSSEX STRATEGIC HA
RG3	Bromley Hospitals NHS Trust	Q07	SOUTH EAST LONDON STRATEGIC HA
RXQ	Buckinghamshire Hospitals NHS Trust	Q16	THAMES VALLEY STRATEGIC HA
RJF	Burton Hospitals NHS Trust	Q26	SHROPSHIRE AND STAFFORDSHIRE STRATEGIC HA
RWY	Calderdale and Huddersfield NHS Trust	Q12	WEST YORKSHIRE STRATEGIC HA
RW3	Central Manchester and Manchester Children's University Hospitals NHS Trust	Q14	GREATER MANCHESTER STRATEGIC HA
RQM	Chelsea and Westminster Healthcare NHS Trust	Q04	NORTH WEST LONDON STRATEGIC HA
RFS	Chesterfield and North Derbyshire Royal Hospital NHS Trust	Q24	TRENT STRATEGIC HA
RBV	Christie Hospital NHS Trust	Q14	GREATER MANCHESTER STRATEGIC HA
RLN	City Hospitals Sunderland NHS Trust	Q09	NORTHUMBERLAND, TYNE & WEAR STRATEGIC HA
REN	Clatterbridge Centre For Oncology NHS Trust	Q15	CHESHIRE & MERSEYSIDE STRATEGIC HA
RJR	Countess Of Chester Hospital NHS Trust	Q15	CHESHIRE & MERSEYSIDE STRATEGIC HA
RXP	County Durham and Darlington Acute Hospitals NHS Trust *	Q10	COUNTY DURHAM AND TEES VALLEY STRATEGIC HA
RN7	Dartford and Gravesham NHS Trust	Q18	KENT AND MEDWAY STRATEGIC HA
RP5	Doncaster and Bassetlaw Hospitals NHS Trust	Q23	SOUTH YORKSHIRE STRATEGIC HA
RNA	Dudley Group Of Hospitals NHS Trust	Q27	BIRMINGHAM AND THE BLACK COUNTRY STRATEGIC HA
RC3	Ealing Hospital NHS Trust	Q04	NORTH WEST LONDON STRATEGIC HA
RWH	East and North Hertfordshire NHS Trust	Q02	BEDFORDSHIRE AND HERTFORDSHIRE STRATEGIC HA
RJN	East Cheshire NHS Trust	Q15	CHESHIRE & MERSEYSIDE STRATEGIC HA
RVV	East Kent Hospitals NHS Trust	Q18	KENT AND MEDWAY STRATEGIC HA
RXR	East Lancashire Hospitals NHS Trust	Q13	CUMBRIA AND LANCASHIRE STRATEGIC HA
RA4	East Somerset NHS Trust	Q22	DORSET AND SOMERSET STRATEGIC HA
RXC	East Sussex Hospitals NHS Trust	Q19	SURREY AND SUSSEX STRATEGIC HA
RVR	**Epsom and St Helier University Hospitals NHS Trust**	Q08	SOUTH WEST LONDON STRATEGIC HA
RDE	Essex Rivers Healthcare NHS Trust	Q03	ESSEX STRATEGIC HA
RDU	Frimley Park Hospital NHS Trust	Q19	SURREY AND SUSSEX STRATEGIC HA
RR7	Gateshead Health NHS Trust	Q09	NORTHUMBERLAND, TYNE & WEAR STRATEGIC HA
RLT	George Eliot Hospital NHS Trust	Q28	COVENTRY, WARWICKSHIRE, HEREFORDSHIRE AND WORCESTERSHIRE STRATEGIC HA

RTE	Gloucestershire Hospitals NHS Trust	Q20	AVON, GLOUCESTERSHIRE AND WILTSHIRE STRATEGIC HA
RJH	Good Hope Hospital NHS Trust	Q27	BIRMINGHAM AND THE BLACK COUNTRY STRATEGIC HA
RJ1	Guy's and St Thomas' NHS Trust	Q07	SOUTH EAST LONDON STRATEGIC HA
RQN	Hammersmith Hospitals NHS Trust	Q04	NORTH WEST LONDON STRATEGIC HA
RCD	Harrogate Health Care NHS Trust	Q11	NORTH AND EAST YORKSHIRE AND NORTHERN LINCOLNSHIRE STRATEGIC HA
RD7	Heatherwood and Wexham Park Hospitals NHS Trust	Q16	THAMES VALLEY STRATEGIC HA
RLQ	Hereford Hospitals NHS Trust	Q28	COVENTRY, WARWICKSHIRE, HEREFORDSHIRE AND WORCESTERSHIRE STRATEGIC HA
RQQ	Hinchingbrooke Health Care NHS Trust	Q01	NORFOLK, SUFFOLK AND CAMBRIDGESHIRE STRATEGIC HA
RQX	Homerton University Hospital NHS Trust	Q06	NORTH EAST LONDON STRATEGIC HA
RWA	Hull and East Yorkshire Hospitals NHS Trust	Q11	NORTH AND EAST YORKSHIRE AND NORTHERN LINCOLNSHIRE STRATEGIC HA
RGQ	Ipswich Hospital NHS Trust	Q01	NORFOLK, SUFFOLK AND CAMBRIDGESHIRE STRATEGIC HA
RR2	Isle Of Wight Healthcare NHS Trust	Q17	HAMPSHIRE AND ISLE OF WIGHT STRATEGIC HA
RGP	James Paget Healthcare NHS Trust	Q01	NORFOLK, SUFFOLK AND CAMBRIDGESHIRE STRATEGIC HA
RNQ	Kettering General Hospital NHS Trust	Q25	LEICESTERSHIRE, NORTHAMPTONSHIRE AND RUTLAND STRATEGIC HA
RJZ	King's College Hospital NHS Trust	Q07	SOUTH EAST LONDON STRATEGIC HA
RCX	Kings Lynn and Wisbech Hospitals NHS Trust	Q01	NORFOLK, SUFFOLK AND CAMBRIDGESHIRE STRATEGIC HA
RAX	Kingston Hospital NHS Trust	Q08	SOUTH WEST LONDON STRATEGIC HA
RXN	Lancashire Teaching Hospitals NHS Trust	Q13	CUMBRIA AND LANCASHIRE STRATEGIC HA
RR8	Leeds Teaching Hospitals NHS Trust	Q12	WEST YORKSHIRE STRATEGIC HA
REP	Liverpool Womens Hospital NHS Trust	Q15	CHESHIRE & MERSEYSIDE STRATEGIC HA
RC9	Luton and Dunstable Hospital NHS Trust	Q02	BEDFORDSHIRE AND HERTFORDSHIRE STRATEGIC HA
RWF	Maidstone and Tunbridge Wells NHS Trust	Q18	KENT AND MEDWAY STRATEGIC HA
RJ6	Mayday Healthcare NHS Trust	Q08	SOUTH WEST LONDON STRATEGIC HA
RPA	Medway NHS Trust	Q18	KENT AND MEDWAY STRATEGIC HA
RQ8	Mid Essex Hospital Services NHS Trust	Q03	ESSEX STRATEGIC HA
RJD	Mid Staffordshire General Hospitals NHS Trust	Q26	SHROPSHIRE AND STAFFORDSHIRE STRATEGIC HA
RXF	Mid Yorkshire Hospitals NHS Trust	Q12	WEST YORKSHIRE STRATEGIC HA
RD8	Milton Keynes General Hospital NHS Trust	Q16	THAMES VALLEY STRATEGIC HA
RP6	Moorfields Eye Hospital NHS Trust	Q05	NORTH CENTRAL LONDON STRATEGIC HA
RTX	Morecambe Bay Hospitals NHS Trust	Q13	CUMBRIA AND LANCASHIRE STRATEGIC HA
RNH	Newham Healthcare NHS Trust	Q06	NORTH EAST LONDON STRATEGIC HA
RM1	Norfolk and Norwich University Hospital NHS Trust	Q01	NORFOLK, SUFFOLK AND CAMBRIDGESHIRE STRATEGIC HA
RVJ	North Bristol NHS Trust	Q20	AVON, GLOUCESTERSHIRE AND WILTSHIRE STRATEGIC HA
RWW	North Cheshire Hospitals NHS Trust	Q15	CHESHIRE & MERSEYSIDE STRATEGIC HA
RNL	North Cumbria Acute Hospitals NHS Trust	Q13	CUMBRIA AND LANCASHIRE STRATEGIC HA
RN5	North Hampshire Hospitals NHS Trust	Q17	HAMPSHIRE AND ISLE OF WIGHT STRATEGIC HA
RAP	North Middlesex University Hospital NHS Trust	Q05	NORTH CENTRAL LONDON STRATEGIC HA
RVW	North Tees and Hartlepool NHS Trust	Q10	COUNTY DURHAM AND TEES VALLEY STRATEGIC HA
RV8	North West London Hospitals NHS Trust	Q04	NORTH WEST LONDON STRATEGIC HA
RNS	Northampton General Hospital NHS Trust	Q25	LEICESTERSHIRE, NORTHAMPTONSHIRE AND RUTLAND STRATEGIC HA
RBZ	Northern Devon Healthcare NHS Trust	Q21	SOUTH WEST PENINSULA STRATEGIC HA
RJL	Northern Lincolnshire and Goole Hospitals NHS Trust	Q11	NORTH AND EAST YORKSHIRE AND NORTHERN LINCOLNSHIRE STRATEGIC HA
RTF	Northumbria Health Care NHS Trust	Q09	NORTHUMBERLAND, TYNE & WEAR STRATEGIC HA
RCS	Nottingham City Hospital NHS Trust	Q24	TRENT STRATEGIC HA
RBF	Nuffield Orthopaedic NHS Trust	Q16	THAMES VALLEY STRATEGIC HA
RTH	Oxford Radcliffe Hospital NHS Trust	Q16	THAMES VALLEY STRATEGIC HA
RGM	Papworth Hospital NHS Trust	Q01	NORFOLK, SUFFOLK AND CAMBRIDGESHIRE STRATEGIC HA

RW6	Pennine Acute Hospitals NHS Trust	Q14	GREATER MANCHESTER STRATEGIC HA
RGN	Peterborough Hospitals NHS Trust	Q01	NORFOLK, SUFFOLK AND CAMBRIDGESHIRE STRATEGIC HA
RK9	Plymouth Hospitals NHS Trust	Q21	SOUTH WEST PENINSULA STRATEGIC HA
RD3	Poole Hospitals NHS Trust	Q22	DORSET AND SOMERSET STRATEGIC HA
RHU	Portsmouth Hospitals NHS Trust	Q17	HAMPSHIRE AND ISLE OF WIGHT STRATEGIC HA
RG2	Queen Elizabeth Hospital NHS Trust	Q07	SOUTH EAST LONDON STRATEGIC HA
RGZ	Queen Mary's Sidcup NHS Trust	Q07	SOUTH EAST LONDON STRATEGIC HA
RFK	Queen's Medical Centre, Nottingham University Hospital NHS Trust	Q24	TRENT STRATEGIC HA
RL1	Robert Jones and Agnes Hunt Orthopaedic and District Hospital NHS Trust	Q26	SHROPSHIRE AND STAFFORDSHIRE STRATEGIC HA
RFR	Rotherham General Hospitals NHS Trust	Q23	SOUTH YORKSHIRE STRATEGIC HA
RHW	Royal Berkshire and Battle Hospitals NHS Trust	Q16	THAMES VALLEY STRATEGIC HA
RDZ	Royal Bournemouth and Christchurch Hospitals NHS Trust	Q22	DORSET AND SOMERSET STRATEGIC HA
RT3	Royal Brompton and Harefield NHS Trust	Q04	NORTH WEST LONDON STRATEGIC HA
REF	Royal Cornwall Hospitals NHS Trust	Q21	SOUTH WEST PENINSULA STRATEGIC HA
RH8	Royal Devon and Exeter Healthcare NHS Trust	Q21	SOUTH WEST PENINSULA STRATEGIC HA
RAL	Royal Free Hampstead NHS Trust	Q05	NORTH CENTRAL LONDON STRATEGIC HA
RQ6	Royal Liverpool and Broadgreen University Hospitals NHS Trust	Q15	CHESHIRE & MERSEYSIDE STRATEGIC HA
RBB	Royal National Hospital For Rheumatic Diseases NHS Trust	Q20	AVON, GLOUCESTERSHIRE AND WILTSHIRE STRATEGIC HA
RRJ	Royal Orthopaedic Hospital NHS Trust	Q27	BIRMINGHAM AND THE BLACK COUNTRY STRATEGIC HA
RA2	Royal Surrey County Hospital NHS Trust	Q19	SURREY AND SUSSEX STRATEGIC HA
RD1	Royal United Hospital Bath NHS Trust	Q20	AVON, GLOUCESTERSHIRE AND WILTSHIRE STRATEGIC HA
RPR	Royal West Sussex NHS Trust	Q19	SURREY AND SUSSEX STRATEGIC HA
RM3	Salford Royal Hospitals NHS Trust	Q14	GREATER MANCHESTER STRATEGIC HA
RNZ	Salisbury Health Care NHS Trust	Q20	AVON, GLOUCESTERSHIRE AND WILTSHIRE STRATEGIC HA
RXK	Sandwell and West Birmingham Hospitals NHS Trust	Q27	BIRMINGHAM AND THE BLACK COUNTRY STRATEGIC HA
RCC	Scarborough and North East Yorkshire Health Care NHS Trust	Q11	NORTH AND EAST YORKSHIRE AND NORTHERN LINCOLNSHIRE STRATEGIC HA
RHQ	Sheffield Teaching Hospitals NHS Trust	Q23	SOUTH YORKSHIRE STRATEGIC HA
RK5	Sherwood Forest Hospitals NHS Trust	Q24	TRENT STRATEGIC HA
RXW	Shrewsbury and Telford Hospitals NHS Trust	Q26	SHROPSHIRE AND STAFFORDSHIRE STRATEGIC HA
RA9	South Devon Health Care NHS Trust	Q21	SOUTH WEST PENINSULA STRATEGIC HA
RM2	South Manchester University Hospitals NHS Trust	Q14	GREATER MANCHESTER STRATEGIC HA
RTR	South Tees Hospitals NHS Trust	Q10	COUNTY DURHAM AND TEES VALLEY STRATEGIC HA
RE9	South Tyneside Health Care NHS Trust	Q09	NORTHUMBERLAND, TYNE & WEAR STRATEGIC HA
RJC	South Warwickshire General Hospitals NHS Trust	Q28	COVENTRY, WARWICKSHIRE, HEREFORDSHIRE AND WORCESTERSHIRE STRATEGIC HA
RHM	Southampton University Hospitals NHS Trust	Q17	HAMPSHIRE AND ISLE OF WIGHT STRATEGIC HA
RAJ	Southend Hospital NHS Trust	Q03	ESSEX STRATEGIC HA
RTG	Southern Derbyshire Acute Hospitals NHS Trust	Q24	TRENT STRATEGIC HA
RVY	Southport and Ormskirk Hospital NHS Trust	Q15	CHESHIRE & MERSEYSIDE STRATEGIC HA
RJ7	St George's Healthcare NHS Trust	Q08	SOUTH WEST LONDON STRATEGIC HA
RBN	St Helens and Knowsley Hospitals NHS Trust	Q15	CHESHIRE & MERSEYSIDE STRATEGIC HA
RJ5	St Mary's NHS Trust	Q04	NORTH WEST LONDON STRATEGIC HA
RWJ	Stockport NHS Trust	Q14	GREATER MANCHESTER STRATEGIC HA
RTP	Surrey and Sussex Healthcare NHS Trust	Q19	SURREY AND SUSSEX STRATEGIC HA
RN3	Swindon and Marlborough NHS Trust	Q20	AVON, GLOUCESTERSHIRE AND WILTSHIRE STRATEGIC HA
RMP	Tameside and Glossop Acute Services NHS Trust	Q14	GREATER MANCHESTER STRATEGIC HA
RBA	Taunton and Somerset NHS Trust	Q22	DORSET AND SOMERSET STRATEGIC HA
RBQ	The Cardiothoracic Centre - Liverpool NHS Trust	Q15	CHESHIRE & MERSEYSIDE STRATEGIC HA

RAS	The Hillingdon Hospital NHS Trust	Q04	NORTH WEST LONDON STRATEGIC HA
RJ2	The Lewisham Hospital NHS Trust	Q07	SOUTH EAST LONDON STRATEGIC HA
RBT	The Mid Cheshire Hospitals NHS Trust	Q15	CHESHIRE & MERSEYSIDE STRATEGIC HA
RTD	The Newcastle Upon Tyne Hospitals NHS Trust	Q09	NORTHUMBERLAND, TYNE & WEAR STRATEGIC HA
RQW	The Princess Alexandra Hospital NHS Trust	Q03	ESSEX STRATEGIC HA
RPC	The Queen Victoria Hospital NHS Trust	Q18	KENT AND MEDWAY STRATEGIC HA
RPY	The Royal Marsden NHS Trust	Q08	SOUTH WEST LONDON STRATEGIC HA
RAN	The Royal National Orthopaedic Hospital NHS Trust	Q05	NORTH CENTRAL LONDON STRATEGIC HA
RL4	The Royal Wolverhampton Hospitals NHS Trust	Q27	BIRMINGHAM AND THE BLACK COUNTRY STRATEGIC HA
RKE	The Whittington Hospital NHS Trust	Q05	NORTH CENTRAL LONDON STRATEGIC HA
RM4	Trafford Healthcare NHS Trust	Q14	GREATER MANCHESTER STRATEGIC HA
RA7	United Bristol Healthcare NHS Trust	Q20	AVON, GLOUCESTERSHIRE AND WILTSHIRE STRATEGIC HA
RWD	United Lincolnshire Hospitals NHS Trust	Q24	TRENT STRATEGIC HA
RRV	University College London Hospitals NHS Trust	Q05	NORTH CENTRAL LONDON STRATEGIC HA
RRK	University Hospital Birmingham NHS Trust	Q27	BIRMINGHAM AND THE BLACK COUNTRY STRATEGIC HA
RJE	University Hospital Of North Staffordshire NHS Trust	Q26	SHROPSHIRE AND STAFFORDSHIRE STRATEGIC HA
RKB	University Hospitals Coventry and Warwickshire NHS Trust	Q28	COVENTRY, WARWICKSHIRE, HEREFORDSHIRE AND WORCESTERSHIRE STRATEGIC HA
RWE	University Hospitals Of Leicester NHS Trust	Q25	LEICESTERSHIRE, NORTHAMPTONSHIRE AND RUTLAND STRATEGIC HA
RBK	Walsall Hospitals NHS Trust	Q27	BIRMINGHAM AND THE BLACK COUNTRY STRATEGIC HA
RET	Walton Centre For Neurology and Neurosurgery NHS Trust	Q15	CHESHIRE & MERSEYSIDE STRATEGIC HA
RBD	West Dorset General Hospitals NHS Trust	Q22	DORSET AND SOMERSET STRATEGIC HA
RWG	West Hertfordshire Hospitals NHS Trust	Q02	BEDFORDSHIRE AND HERTFORDSHIRE STRATEGIC HA
RFW	West Middlesex University NHS Trust	Q04	NORTH WEST LONDON STRATEGIC HA
RGR	West Suffolk Hospitals NHS Trust	Q01	NORFOLK, SUFFOLK AND CAMBRIDGESHIRE STRATEGIC HA
RA3	Weston Area Health NHS Trust	Q20	AVON, GLOUCESTERSHIRE AND WILTSHIRE STRATEGIC HA
RGC	Whipps Cross University Hospital NHS Trust	Q06	NORTH EAST LONDON STRATEGIC HA
RN1	Winchester and Eastleigh Healthcare NHS Trust	Q17	HAMPSHIRE AND ISLE OF WIGHT STRATEGIC HA
RBL	Wirral Hospital NHS Trust	Q15	CHESHIRE & MERSEYSIDE STRATEGIC HA
RWP	Worcestershire Acute Hospitals NHS Trust	Q28	COVENTRY, WARWICKSHIRE, HEREFORDSHIRE AND WORCESTERSHIRE STRATEGIC HA
RPL	Worthing and Southlands Hospitals NHS Trust	Q19	SURREY AND SUSSEX STRATEGIC HA
RRF	Wrightington, Wigan and Leigh NHS Trust	Q14	GREATER MANCHESTER STRATEGIC HA
RCB	**York Hospitals NHS Trust**	Q11	NORTH AND EAST YORKSHIRE AND NORTHERN LINCOLNSHIRE STRATEGIC HA

Healthcare Commission
Inpatient Survey 2003/04

1. Introduction

This document outlines the method used by the Healthcare Commission (formerly the Commission for Health Improvement) to group and score the performance indicator questions included within the Inpatient Survey, carried out by NHS acute and specialist trusts in Spring 2004.

2. Domains: Selected indicator questions

The Inpatient core survey consists of 50 pre-coded questions, and a section for further comments. Of these, 41 questions were classified as being potential evaluative questions, and were allocated to one of the five Department of Health patient experience domains (see Figure 2.1).

Figure 2.1: Domains of patient experience

Domains:

- Access and waiting
- Safe, high quality, coordinated care
- Better information, more choice
- Building relationships, and
- Clean, comfortable, friendly place to be.

The criteria listed in Figure 2.2 were used to assess the suitability of each individual question, in terms of its viability as an indicator of performance. Using these criteria, 25 questions were selected as performance indicators. See Appendix 1 for the questions included within each domain.

Figure 2.2 Criteria for selecting performance indicator questions:

- Patient priorities:

  Questions should cover issues that are known to be important to patients.

- Wide range of issues within domains:

  The questions should cover a broad range of topics and services within each domain.

- Overlap:

  Items should be selected so there is minimal overlap with other questions included in the PIs.

- Ease of evaluating responses:

  Questions should have clear/uncontroversial positive and negative response categories, and it should be clear that the topic covered is under the responsibility and range of influence of the Trust.

- Non-response:

  Questions should have low numbers of missing responses

3. Scoring: Individual indicator questions

The indicator questions are scored using a scale of 0 to 100. A listing of scores assigned to the responses to each individual question is provided in Appendix 2.

The scores represent the extent to which the patient's experience could have been improved. A score of 0 is assigned to all responses that reflect considerable scope for improvement, whereas an answer option that has been assigned a score of 100 refers to a positive patient experience. Where options have been provided that do not have any bearing on the trusts performance in terms of patient experience, the responses are classified as "missing". For example, where the patient has stated they cannot remember or do not know the answer to the question, a score will not be given. Effectively it will be treated as a non-responder.

For example, question 43 (see Figure 3.1) asks whether the respondent felt they were treated with respect and dignity. The option of "No" has been allocated a score of 0, as this suggests that improvements to the patient experience are required. A

score of 100 has been assigned to the option “Yes, always” as it reflects a positive patient experience. The option, “Yes, sometimes”, has been assigned a score of 50 as the patient felt that some degree of respect and dignity was received, although not consistently. Hence it has been placed on the midpoint of the scale.

Figure 3.1 Scoring example: Question 24

43. Overall, did you feel you were treated with respect and dignity while you were in the hospital?	
Yes, always	100
Yes, sometimes	50
No	0

Where a number of options lie between the negative and positive responses, they are placed in appropriate positions along the scale. For example, question 3 asks respondents how long they waited for admission to a room or ward and bed, following arrival (see Figure 3.2). The options include:

- Less than 1 hour
- At least 1 hour but less than 2 hours
- At least 2 hours but less than 4 hours
- At least 4 hours but less than 8 hours
- 8 hours or longer
- Can’t remember
- I did not have to wait

A score of 100 will be assigned to a response that the patient waited less than an hour, as this is best practice in terms of patient experience. A response that the wait was eight hours or longer would be given a score of 0, and so the remaining three answers would be assigned a score that reflects their position in terms of best practice, spread evenly across the scale. Hence the option “At least 1 hour but less than 2 hours” has been assigned a score of 75, “At least 2 hours but less than 4 hours” will achieve a score of 50, and the response that “At least 4 hours but less than 8 hours” wait was experienced would score 25 for the trust.

If the patient had not had to wait, or did not know/could not remember how long the wait had been, this would be classified as a “missing” response, as these options are not a direct measure of how long a person had to wait to get admitted.

Figure 3.2 Scoring example: Question 3 Inpatient Survey

3. Following arrival at the hospital, how long did you wait before admission to a room or ward and bed?	
Less than 1 hour	100
At least 1 hour but less than 2 hours	75
At least 2 hours but less than 4 hours	50
At least 4 hours but less than 8 hours	25
8 hours or longer	0
Can’t remember	M
I did not have to wait	M

4. Methodology:

The national proportions and a more detailed explanation of the performance indicator methodology will be available on the Healthcare Commission website in the near future.

Appendix 1:
Performance indicator questions, grouped within each domain

Access and Waiting
3. Following arrival at the hospital, how long did you wait before admission to a room or ward and bed?
4. How do you feel about the length of time you were on the waiting list before your admission to hospital?
7. Was your admission date changed by the hospital?
9. From the time you arrived at the hospital, did you feel that you had to wait a long time to get to a bed on a ward?

Safe, high quality, coordinated care
17. Did you have confidence and trust in the doctors treating you?
20. Did you have confidence and trust in the nurses treating you?
22. In your opinion, were there enough nurses on duty to care for you in hospital?
23. Sometimes in a hospital, a member of staff will say one thing and another will say something quite different. Did this happen to you?
30. How many minutes after you used the call button did it usually take before you got the help you needed?
37. How long was the delay [of your discharge on the day you left hospital]? (Scored negatively only if delay was due to medicines, doctor or ambulance, as reported in q36)
40. Did a member of staff tell you about any danger signals you should watch for after you went home?

Better information, more choice

24. Were you involved as much as you wanted to be in decisions made about your care and treatment?

25. How much information about your condition and treatment was given to you?

38. Did a member of staff explain the purpose of the medicines you were to take at home in a way you could understand?

39. Did a member of staff tell you about medication side effects to watch for when you went home?

Building relationships

16. When you had important questions to ask a doctor, did you get answers that you could understand

18. Did doctors talk in front of you as if you weren't there?

19. When you had important questions to ask a nurse, did you get answers that you could understand

21. Did nurses talk in front of you as if you weren't there?

26. If your family or someone else close to you wanted to talk to a doctor, did they have enough opportunity to do so?

Clean, comfortable, friendly place to be

13. In your opinion, how clean was the hospital room or ward that you were in?

15. How would you rate the hospital food?

29. Were you given enough privacy when being examined or treated?

34. Do you think the hospital staff did everything they could to help control your pain?

43. Overall, did you feel you were treated with respect and dignity while you were in the hospital?

Appendix 2:
Scoring of individual indicator questions

3. Following arrival at the hospital, how long did you wait before admission to a room or ward and bed?	
Less than 1 hour	100
At least 1 hour but less than 2 hours	75
At least 2 hours but less than 4 hours	50
At least 4 hours but less than 8 hours	25
8 hours or longer	0
Can't remember	M
I did not have to wait	M

4. How do you feel about the length of time you were on the waiting list before your admission to hospital?	
I was admitted as soon as I thought was necessary	100
I should have been admitted a bit sooner	50
I should have been admitted a lot sooner	0

7. Was your admission date changed by the hospital?	
No	100
Yes, once	67
Yes, 2 or 3 times	33
Yes, 4 times or more	0

9. From the time you arrived at the hospital, did you feel that you had to wait a long time to get to a bed on a ward?	
Yes, definitely	0
Yes, to some extent	50
No	100

13. In your opinion, how clean was the hospital room or ward that you were in?	
Very clean	100
Fairly clean	67
Not very clean	33
Not at all clean	0

15. How would you rate the hospital food?	
Very good	100
Good	67
Fair	33
Poor	0
I did not have any hospital food	M

16. When you had important questions to ask a doctor, did you get answers that you could understand	
Yes, always	100
Yes, sometimes	50
No	0
I had no need to ask	M

17. Did you have confidence and trust in the doctors treating you?	
Yes, always	100
Yes, sometimes	50
No	0

18. Did doctors talk in front of you as if you weren't there?	
Yes, often	0
Yes, sometimes	50
No	100

19. When you had important questions to ask a nurse, did you get answers that you could understand	
Yes, always	100
Yes, sometimes	50
No	0
I had no need to ask	M

20. Did you have confidence and trust in the nurses treating you?	
Yes, always	100
Yes, sometimes	50
No	0

21. Did nurses talk in front of you as if you weren't there?	
Yes, often	0
Yes, sometimes	50
No	100

22. In your opinion, were there enough nurses on duty to care for you in hospital?	
There were always or nearly always enough nurses	100
There were sometimes enough nurses	50
There were rarely or never enough nurses	0

23. Sometimes in a hospital, a member of staff will say one thing and another will say something quite different. Did this happen to you?	
Yes, often	0
Yes, sometimes	50
No	100

24. Were you involved as much as you wanted to be in decisions made about your care and treatment?	
Yes, definitely	100
Yes, to some extent	50
No	0

25. How much information about your condition and treatment was given to you?	
Not enough	0
The right amount	100
Too much	0

26. If your family or someone else close to you wanted to talk to a doctor, did they have enough opportunity to do so?	
Yes, definitely	100
Yes, to some extent	50
No	0
No family or friends were involved	M
My family did not want or need information	M
I did not want my family or friends to talk to a doctor	M

29. Were you given enough privacy when being examined or treated?	
Yes, always	100
Yes, sometimes	50
No	0

30. How many minutes after you used the call button did it usually take before you got the help you needed?	
0 minutes/right away	100
1-2 minutes	75
3-5 minutes	50
More than 5 minutes	25
I never got help when I used the call button	0
I never used the call button	M

34. Do you think the hospital staff did everything they could to help control your pain?	
Yes, definitely	100
Yes, to some extent	50
No	0

Note: Q37 is scored only where the main reason for delay was due to waiting for medicines, to see the doctor, or for an ambulance (as indicated in q36). If a respondent stated that no delay was experienced (q35) a score of 100 is automatically given. The option of "something else" causing the delay in q37 is excluded from the analysis, as the exact cause can not be attributed to trust performance

37. How long was the delay [of your discharge on the day you left hospital]? (see note below)	
Up to 1 hour	75
Longer than 1 hour but no longer than 2 hours	50
Longer than 2 hours but no longer than 4 hours	25
Longer than 4 hours	0

38. Did a member of staff explain the purpose of the medicines you were to take at home in a way you could understand?	
Yes, completely	100
Yes, to some extent	50
No	0
I did not need an explanation	M
I had no medicines	M

39. Did a member of staff tell you about medication side effects to watch for when you went home?	
Yes, completely	100
Yes, to some extent	50
No	0
I did not need an explanation	M

40. Did a member of staff tell you about any danger signals you should watch for after you went home?	
Yes, completely	100
Yes, to some extent	50
No	0
It was not necessary	M

43. Overall, did you feel you were treated with respect and dignity while you were in the hospital?	
Yes, always	100
Yes, sometimes	50
No	0

NHS National Patient Survey Programme: data weighting issues

1. Introduction

The following key outputs are produced on most of the surveys carried out on the NHS National Patient Survey Programme each year:

- A key findings report that summarises the key findings at national level.
- Trust level tables presenting the percentage of responses for all questions on the survey plus national response totals for England.
- Benchmark reports that compare the results of each NHS trust with the results for other trusts.
- Performance indicators for use on the annual NHS performance rating.

Weighted data have been used to produce the key findings report and the national totals displayed in the trust level tables since 2003/4. The benchmark reports and performance indicators have always been derived from weighted data.

This document describes the approach taken to weighting the data presented in the key findings report and the national totals displayed in the trust level tables on the surveys listed below.

- Acute trust inpatient survey,
- Acute trust outpatient surveys,
- Acute trust emergency department surveys,
- Acute trust young patients survey,
- Primary Care Trust (PCT) patient surveys,
- Ambulance trust survey,
- Mental health trust service user surveys.

The weighting method used to derive performance indicators is described in a separate document specific to each survey. Those documents description the derivation of performance indicators have been included in the survey documentation deposited with the UK Data Archive.

2. Samples

In each of these surveys, the vast majority of trusts sampled 850 patients[1]. Different sampling methods were chosen for different surveys because of the particular constraints of the sampling frame to be used in each case: sampling methods used are summarised in Table 1.

[1] In a few exceptional cases trusts were unable to sample 850 recent patients because of their low throughput of patients. Where this occurred, trusts were requested to contact the NHS Surveys Advice Centre and smaller sample sizes were agreed.

Table 1 Summary of sampling methods

Survey	Sampling method
Inpatients	850 consecutively discharged *patients* aged 16+
Outpatients	Systematic sample* of outpatient *attendances* during a reference month by those aged 16+
Emergency Department	Systematic sample* of emergency department *attendances* during a reference month by those aged 16+
Young patients	850 consecutively discharged *patients:* overnight and day cases of those aged 0-17
PCT	Systematic sample* of GP registered *patients* aged 16+
Ambulance trusts	Multi-stage sample involving systematic and simple random sampling of patients aged 16+ *attended* during a reference week.
Mental health trusts	Simple random sample of *service users* aged 16-64 on CPA who were seen during a three-month reference period

Further details of survey populations and sampling methods can be found in the guidance notes for individual NHS patient surveys at www.nhssurveys.org.

It is worth noting that the sampling method used determines the population about which generalisations can be made. Different approaches were taken in the different surveys, meaning that results generalise to correspondingly different types of population. For the surveys of inpatients and young inpatients, the survey populations comprised *flows of patients* attending over particular time periods (ie the population is one of *people* attending), whereas for the outpatients, mental health services users, and ambulance trusts and Emergency Department surveys the survey populations comprised *attendances* over particular time periods. The PCT survey population comprised the *stock* of all GP registered *patients*.

Below we point out some of the implications of these differences.

Patients v. attendances: the difference between *attendances* and *patient*s as used here may be understood by comparing two hypothetical equal sized groups of patients: group 1 patients attended once during the reference period and group 2 patients attended twice. In such a situation, a sample based on patients will represent the two groups equally, whereas a sample based on attendances will deliver twice as many from group 2 as from group 1[2]. In other words, frequently attending patients will have a greater impact on results where samples are based on attendances than where they are based on unique patients.

Stock v. flow: for a stock sample attendance frequency will have no bearing on the results. For a flow sample the make-up of the survey population will depend upon the length of the reference period used, such that relatively infrequent attendees will make up larger proportions of the sample (and hence survey population) with longer reference periods. In other words, if a survey uses a flow sample with a short

* This involves sorting the sample frame based on some critical dimension(s) – eg age – and selecting units at fixed intervals from each other starting from a random point. For more detailed information, see the survey guidance documents for individual surveys.

2 This is a slight simplification as it assumes a with-replacement sampling method. This does not, however, affect the essential point.

reference period, its results will be less influenced by the experiences of infrequent attendees than they would have been had a longer reference period been used[3].

3. Weighting the results

Weighting to trust and patient populations
In the key findings report and the national totals displayed in the trust level tables of surveys on the 2003/4 and 2004/5 NHS National Patient Survey Programmes, patient data were weighted to ensure that results related to the *national population of trusts*. The aim of this was to give all trusts exactly the same degree of influence when calculating means, proportions and other survey estimates. National estimates produced after weighting in this way can be usefully regarded as being estimates for the *average* trust: this was felt to be the most appropriate way to present results at a national level. However, it is worth noting that an alternative approach could have been taken, namely to weight to the *national population of patients*. This would be the appropriate approach to take if the primary interest had been to analyse characteristics of patients rather than characteristics of trusts.

Weighting to the population of trusts ensures that each trust has the same influence as every other trust over the value of national estimates. If unweighted data were used to produce national estimates, then trusts with higher response rates to the survey would have a greater degree of influence than those who received fewer responses. Had we weighted to the national population of patients, a trust's influence on the value of a national estimate would have been in proportion to the size of its eligible patient population[4].

4. Illustrative example

To illustrate the difference between the two approaches, we have devised a simple fictitious example concerning the prevalence of smoking in three universities, A, B and C, situated in a single region. This is shown in table 2.

Table 2 Students and smoking

University	No. students	Proportion smoking
A	10000	0.2
B	8000	0.3
C	1000	0.6
Regional total	19,000	

[3] It is worth noting that, conceptually, a stock sample can be regarded as a flow sample with an infinite reference period, so long as all registered patients have a non-zero probability of attending.
[4] For example, for the ambulance survey this would be the number of attendances of eligible patients aged 16+ during the reference week.

If we were interested in knowing the smoking prevalence of the average university, we would take the simple mean of the three proportions:

1... prevalence in average university = (0.2 + 0.3 +0.6)/3 = 0.3667.

If, on the other hand, we were interested in knowing what proportion of students smoked in the region we would have to multiply each university's proportion of smokers by its student population to give an estimate of total smokers in the university, sum these totals across universities and divide by regional student total:

2... regional prevalence = ((0.2*10000) + (0.3*8000) + (0.6*1000))/19000
= 0.2632.

5. Weighting for national level patient survey estimates

As stated above, for estimates from the NHS National Patient Survey Programme, we were interested in taking the equivalent to approach 1 rather than 2. This could have been done in one of two ways:

a. analyse a dataset of *trusts* and apply no weight – this would entail calculating estimates for each trust and then taking means of these estimates.
b. analyse a dataset of *patients* after weighting each case – weights must be calculated to ensure that each trust has the same (weighted) number of responses for each item.

These two approaches produce identical estimates, but the latter method is the one used on the 2004/5 national patient surveys (the former approach was used on the 2003/04 surveys). In order to use weights to eliminate the influence of variable response rates, it is necessary to base them on the inverse of the number of responses for each trust, such that the weight for each trust is equal to k/n_{iq}
where:
k is a constant
n_{iq} is the number of responses to question q within trust i).

Although k may take any value, in practice it is set to the mean number of respondents answering the relevant question in all trusts because this equalises weighted and unweighted sample sizes for the national level results. Thus, the formula used to calculate weights can be expressed as:

$$w_{iq} = \frac{\overline{n}_q}{n_{iq}}$$

Example of weighting to the trust population
By way of example, in table 3 we have three trusts, X, Y and Z in a particular area: in each trust a different number of patients responded and in each a different estimate of proportion of patients who didn't like the food they were given was obtained.

Note first, that if these data were held in a trust level dataset (ie with one record per trust) we would have calculated the simple unweighted trust-based mean as:

trust mean = (0.2 +0.23 +0.3) / 3 = 0.2433

Table 3 Weighting to trust population

Trust	1 No. responders to food question in trust (n_{iq})	2 Proportion of respondents disliking the food	3 Weight	1 * 2 * 3	1 * 3
X	600	0.2	0.7778	93.33333	466.6667
Y	500	0.23	0.9333	107.3333	466.6667
Z	300	0.3	1.5556	140	466.6667
All	1400				
Mean	466.6667				

However, in practice we often apply a weight in a patient level dataset instead. In the table 3 above, we have calculated the weight as:

trust weight = (mean value of n_{iq})/ n_{iq}.

For example the weight for trust X is calculated as 466.6667/600 = 0.7778.

By applying these weights (eg by using the SPSS "weight by" command) when running tables showing proportion of patients disliking the food, we obtain the simple trust based means. The way this works when calculating the proportion can be seen below:

numerator for proportion = (600 * 0.2*0.7778) + (500 * 0.23 * 0.9333)
+ (300 * 0.3 * 1.5556) = 340.6667

denominator for proportion = (600 *0.7778) + (500 * 0.9333)
+ (300 * 1.5556) = 1400

Estimate = 340.6667 / 1400 = 0.2433

As can be seen, this is same as the simple mean calculated using a trust-level dataset shown above.

If we did not weight, our estimate would be 325 / 1400 = 0.2321. In other words, the overall estimate would be dragged towards the estimates for those trusts with larger numbers of respondents.

Dealing with missing data and filtered questions

The weighting method outlined above involves the calculation of weights for each combination of trust and question. An alternative might have been to simply calculate a single weight per trust where trust weight = (mean value of n_{icases})/ n_{icases} (where n_{icases} is the of total number of responding *cases* in trust *i*). This would be a simpler approach to implement, as it would involve substantially fewer calculations and different weights would not have to be applied for each question. In spite of this, it was considered inappropriate to use this simpler method because the number of responses varies betweens questions.

Numbers of responses for different questions vary because not every respondent will answer every question. The largest source of variance is filtering – the surveys frequently include 'filter' questions that direct patients to answer only the parts of the questionnaire which are relevant to them. For example, a patient may be prompted to skip questions on medicines if they have not used any in the past year.

Patients may also fail to answer a particular question either in error, because they refused, or because they were unsure how to answer. Similarly, responses may be missing because a patient has given multiple responses for a question. For these reasons we often find that, in practice, the number of respondents answering a particular question in trust *i* (n_{iq}) is less than n_{icases}. If the proportion of respondents answering a particular question varies across trusts, then applying the trust weight as defined in the last paragraph will not give each trust exactly the same level of influence on the survey estimate. Generally, this variation should be trivial for well constructed and well laid out *unfiltered* questions, because the great majority of respondents will answer them in all trusts. However, the variation may in some cases become too great to ignore, particularly where questions are filtered. This is a particular issue where the numbers of people within a trust responding in certain ways to a 'filter' question are likely to be related to the type of trust – for instance, some specialist acute hospitals might have a very high proportion of patients responding to questions about elective admissions, but few or none responding to questions about emergency admission. Clearly, in such cases, using a single set of weights for all questions would be insufficient.

For other applications users may be content to calculate a weight based upon n_{icases}. If there is no substantial variation in the proportion of respondents answering questions of interest across trusts, this approach will deliver very similar results to those obtained using n_{iq}. Likewise, if the number of people being filtered past or skipping questions is of interest, it is possible to include these outcomes as 'dummy' responses for each question and therefore analyse data from different questions whilst retaining a constant base and thus ensuring all trusts have an equal degree of input.

What weight should be used?

Weighting to the trust population provides the most appropriate national estimates for trust comparisons. It is however, not the most appropriate approach for many other purposes. If the main area of interest relates to patients rather than trusts, it will be necessary to weight data to the national population of patients. This will require the calculation of new weights. Examples of what we mean by areas of interest are shown below:

<u>Patients</u> <u>Trusts</u>

- What proportion of patients nationally felt that the toilets and bathrooms were not very or not at all clean?
- Were males or females more likely to say that toilets and bathrooms were not very or not at all clean?
- What proportion of patients in the average trust felt that the toilets and bathrooms were not very or not at all clean?
- Were small acute trusts more or less likely than medium / large acute trusts to have patients who said that toilets and bathrooms were not very or not at all clean?

Calculating patient population weights

Although patient population weights have not been calculated, users may well need to use these for some of their analyses. These should be calculated as:

$$\text{patient population weight} = (k * N_i)/ n_{icases},$$

where:

n_{icases} is the number of respondents in trust *i*[5],
N_i is the number eligible patients in the survey population in trust *i*,
k is a constant, which is usually set so as to equalise the overall weighted and unweighted sample sizes.

Probably the main difficulty in calculating this weight will be obtaining a reliable figure for N_i. N_i is the population to which each trust's results are to be generalised. Ideally this should be the size of the population *from which the sample was actually selected.* For example, for ambulance trusts, N_i would ideally be the total number of attendances during the exact reference week (ie the number of cases from which the sample of 850 was actually drawn). However, we acknowledge that this information is unlikely to be available, and it will therefore be necessary to substitute an estimate instead.

In doing this it should be borne in mind that the definition of the population from which the estimate of N_i will be derived should be as close as possible to the definition of the population *from which the sample was actually selected*. For example, the trust population figures used to calculate weight N_i for the PCT surveys should relate to the stock of patients and not the flow of patients or attendances; a flow sample should, ideally, be weighted to a population using the same reference period (eg the Emergency Department data should be weighted to *monthly* throughput). Furthermore the population figures used for weighting should, of course, relate to the same year (at least!) as that in which the survey was conducted.

Of course, if there is a dearth of available population information, non-ideal population data have to be used. If this is the case, it is worthwhile spelling out the additional assumptions that will, by implication, have to be being made. For example, if inpatient data are weighted to inpatient attendance figures instead of patient flows,

[5] In principle it would be possible to use n_{iq} in this formula for unfiltered questions (it could not be done for filtered questions because this would require us to substitute number in the population eligible for the filter question – an unknown value - for N_i). To our knowledge, in practice this approach is *never* taken.

an implicit assumption is being made that the proportion of patients making *n* attendances over the reference period is constant across trusts[6].

Use of unweighted data
If a user decides simply to analyse unweighted data, the implications of so doing need to be understood. Given the sampling methods used, an unweighted sample would deliver approximately equal numbers of responses if response rate did not vary widely between trusts. In effect this would mean that the sample would be approximately equivalent to one weighted by:

trust weight = (mean value of n_{icases})/ n_{icases}

As such, it could be regarded as crudely representing the population of trusts (crudely, because in practice response rates *did* vary, and as a result trusts with good response rates would have greater influence on the results that would trusts with poor response rates). It would, however, be wholly inappropriate for analyses of *patients*. This is because, unweighted, the data will substantially under-represent patients in trusts with large numbers of patients, and substantially over-represent patients in trusts with small numbers of patients. To the extent that that large and small trusts differ systematically from one another on survey variables, the use of unweighted data will introduce systematic bias into the results.

Patten Smith
4 November 2005

[6] An added (but, in practice, trivial) complication is that for the inpatient and young patient surveys there is no "perfect" definition for a population data reference period. This is because the sampling method itself used a variable reference period: trusts with large patient throughputs used shorter reference periods than trusts with smaller throughputs.

NHS PATIENT SURVEY PROGRAMME

ACUTE TRUSTS: IN PATIENT 2004

About the survey

The In Patient Survey 2004 is part of the NHS Patient Survey Programme, initiated by the Department of Health and now the responsibility of the Healthcare Commission (CHAI). More than 88,000 patients from 169 NHS trusts in England participated in this survey. The survey was designed to provide actionable feedback to each participating trust on patients' views of the care they had received, as well as providing CHAI with patient focused indicators to feed into the 2004 performance ratings for acute and specialist NHS trusts. Further details of the survey methodology can be found in the separate note on the website.

About the benchmarking reports

Each report presents question level results for an individual trust. The In Patient questionnaire contained 50 precoded questions, 39 of which could be evaluated as an indicator of performance. These 39 questions were allocated to one of the five domains of patient experience used by the Department of Health:

- access and waiting
- safe, high quality, coordinated care
- better information, more choice
- building relationships
- clean, comfortable, friendly place to be

An 'overall impression' question asked patients to rate the care they had received in the emergency department. This report presents the results on each evaluative question within these five domains as a set of charts and tables. Reports may be found:
http://www.healthcarecommission.org.uk/NationalFindings/Surveys/PatientSurveys/fs/en?CONTENT_ID=4006194&chk=56KWBT

Interpreting the charts

For each question in the survey, the individual responses were scored on a scale of 0 to 100, depending on the extent to which the patient's experience could have been better. A score of 100 represents the best possible response. The average scores for each trust for each question were calculated[1].

Each bar represents the range of results across all trusts that took part in the survey for one question.

The bar is divided into three coloured segments:

- the left-hand end of the bar (coloured red) shows the scores for the 20% of trusts with the lowest scores
- the right-hand end of the bar (coloured green) shows the scores for the 20% of trusts with the highest scores
- the middle section of the bar (coloured orange) represents the range of scores for the remaining 60% of trusts

The score for this trust is shown on each bar by a white diamond. So, for example, if the diamond is in the green section of the bar, the trust is in the best 20% of trusts in England.

The line either side of the diamond shows the amount of uncertainty surrounding the trust value, as a result of random fluctuation[2].

Further information

Full details of the survey methodology can be found at:
http://www.nhssurveys.org/docs/Inpatient_Guidance2004.pdf

The questionnaire and scores given to each response can be found at:
http://www.healthcarecommission.org.uk/assetRoot/04/01/48/73/04014873.pdf

More information on the NHS Patient Survey Programme is available on the NHS Surveys Advice Centre website (www.nhssurveys.org).

More information on NHS performance ratings is available at:
http://www.healthcarecommission.org.uk/InformationForServiceProviders/PerformanceRatings/fs/en

1 The results have been weighted by the age and sex of respondents. The trust-level results are standardised, so that their age-sex profile reflects the national age-sex distribution (based on all of the survey respondents). This is so that results can be compared between trusts with different patient profiles.

2 This is the 95% confidence interval indicating that in 95% of cases we can expect the true value to be within this range. Where fewer than 30 people answered a question at this trust the diamond is not shown because the uncertainty around the result would be too great. Note also that when identifying trusts with the highest and lowest scores and thresholds, trusts with fewer than 30 respondents have not been included.

NHS trust-based patient surveys: acute hospital trusts

Adult Inpatients 2003/04

Listening to your patients

Last updated 28 November 2003

This document is available from the NHS Survey Advice Centre website at:

http://www.nhssurveys.org

Contacts

Advice Centre for the NHS Patient Survey Programme
Picker Institute Europe
King's Mead House
Oxpens Road
Oxford
OX1 1RX

Tel: 01865 208127
E-mail: inpatient.data@pickereurope.ac.uk

Updates

Before you start work on your survey, check that you have the latest version of this document, as there might be some small amendments from time to time. (The date of the last update is on the front page.) In the very unlikely event that there are any major changes, we will e-mail all trust contacts directly to inform them of the change.

Paediatric Survey

Acute NHS Trusts that care for children will also be required to carry out a Children and Young Patients survey (of patients aged 0-17) in 2003/04. A separate guidance manual and questionnaire for this survey will be available from the NHS Survey Advice Centre website early in 2004.

Changes to the procedures outlined in this document

It is not permissible to deviate from the agreed protocol as set out in the guidance manual. For example, offering financial inducements or lottery prizes to respondents; or translation of questionnaires into other languages is not acceptable. The terms of the ethical approval does not permit these types of alteration. Furthermore, such alterations might mean that the comparability of the survey would be compromised, and this could affect the calculation of performance indicators. If trusts want to make any adjustments, they will need to seek local research ethics approval, and check with the Advice Centre that the proposed alteration would not compromise comparability.

Please direct questions or comments about this guidance to:

rachel.reeves@pickereurope.ac.uk

CONTENTS

1 Introduction: patient feedback and the NHS Plan

1.1 The Commission for Health Improvement

The national patient survey programme is now being led by the Commission for Health Improvement (CHI). The Commission for Health Improvement's aim is to improve the quality of patient care in the NHS. Patients' experience of health services is at the heart of CHI's work.

1.2 Why we need patient feedback

Quality in health and medical care has two distinct dimensions. One has to do with the quality of care from the perspective of professional, technical standards; and the other dimension concerns the quality of care from the perspective of patients. Understanding the way patients experience the care they receive is essential to a complete assessment of the quality of health care, and this can only be obtained by asking the patients themselves.

It is important to adopt systematic, appropriate and effective ways to ask patients about their experiences, and use this information to shape and improve the way health care is delivered. This manual is designed to help staff in acute NHS Trusts to obtain patient feedback. It also provides guidance on how you may use the information in quality improvement programmes and for monitoring purposes. By following this guidance, you will also help to ensure that the survey results from your trust are comparable with other trusts, and with national benchmarks.

1.3 Patient feedback and the NHS Plan

Improving the experience of each individual patient is at the centre of the NHS Plan reforms. Obtaining feedback from patients and taking account of their views and priorities are vital for the delivery of the plan and for driving real service improvements.

The plan requires all NHS Trusts to carry out local surveys asking patients their views on the services they have received. It is intended that measuring patients' experiences in a structured way will act as an incentive to make patient experience a real and central priority for the NHS. The NHS Trust Survey programme is an important mechanism for making the NHS more patient-focused and provides a quantifiable way of achieving this. Patient surveys can help deliver the NHS Plan commitments by:

- Providing information to support local quality improvement initiatives
- Tracking changes in patient experience locally over time
- Providing information for active performance management
- Providing information to support public and parliamentary accountability.
- Providing information for CHI/CHAI's programme of reviews and inspections.

1.4 Performance indicators

Information drawn from the core questions of the Inpatient Survey will be used by CHI to create headline NHS Performance Indicators. These indicators will be used in Acute and Specialist Trust Performance Ratings, due for publication in summer 2004.

In addition to the performance indicators, CHI will publish benchmarking data from the survey to allow trusts to make meaningful comparisons between themselves based on reliable data. Information collected nationally in a consistent way is also essential to support public and parliamentary accountability. By asking each acute trust to carry out surveys of both Adult Inpatients and Children in a consistent way, CHI is building up a detailed picture across the country of patients' experiences in acute NHS Trusts. Also, by repeating the same surveys on a bi-annual basis, trusts will be able to monitor their own performance over time.

1.5 Basic requirements for NHS trust inpatient surveys

In order for comparisons between and within trusts to be accurate, fair and effective, it is essential that the surveys be carried out using a standard procedure in all acute NHS Trusts. Those standards are set out in detail later in this document. In summary, they are as follows:

- You must contact the Survey Advice Centre by **31st October 2003** and tell them who is carrying out your survey (i.e. whether it will be carried out by an approved contractor or in-house), and who in your trust will be responsible for monitoring the survey's progress (e-mail: inpatient.data@pickereurope.ac.uk).
- A postal questionnaire survey must be carried out.
- The sampling procedure set out in this guidance must be followed.
- The questionnaire must be sent to 850 adult inpatients recently discharged alive from the trust (excluding maternity and psychiatry patients).
- The sample of patients must consist of the most recent consecutive discharges up to the last date of **either** September 2003 **or** October 2003 **or** November 2003.
- The response rate should be at least 60% and the sample size must be 850 patients. That is, you should get 500 returned questionnaires from the 850 mailed out. Three mailings will be necessary to achieve this target.
- The data from the core questions, and the required information about the patient sample, must be submitted to the Survey Advice Centre in the form outlined in 13.5 - *Submitting data to the Patient Survey Advice Centre* by **31st March 2004**.
- Two copies each of the questionnaire you used, and the covering letters for **each mailing** must be submitted to the Survey Advice Centre in the form outlined in 13.5 - *Submitting data to the Patient Survey Advice Centre* by **31st March 2004**.
- The questionnaire must include the 50 core questions. See Section 10 - *The core questions and question bank*.
- The data must be checked carefully for errors before submitting it to the Advice Centre. See Section 13 - *Entering data*
- You must keep paper copies (or scanned pictures of the full questionnaires, including the front page) of all questionnaires returned to you until 31st August 2004 but please **do not** send these to the Advice Centre.

1.6 How to use this guide

Trusts have the option of conducting the survey in house or using an approved contractor (see Section 4). Whichever route you take, you will need to address the guidance in Sections 1 to 10 and 14 to 16 of this guide. Sections 11, 12 and 13 cover the practicalities of mailing out the survey, following-up responses and processing the results. These sections will be most relevant to approved contractors, or trusts undertaking the surveys themselves.

2 Setting up a project team

Whether you choose to do the survey in-house, or to use an Approved Survey Contractor, you will need to set up a project team. Too often, key players and stakeholders are left out of planning and implementation phases of a patient survey and are forced to respond to results for which they feel no ownership. The best way to ensure that your survey is a success is to work hard *in the beginning* to involve those people who have the most impact on patients' experiences and who will be responsible for responding to the results of the survey.

- **Establish a workgroup.** Put together a small team of people who are key stakeholders and involve them in decisions. Groups to consider include:
    - Board members
    - Members of Patients' Forum (where established)
    - Doctors, nurses and other health care staff
    - Administrators
    - Medical records personnel or Patient Administration System staff
    - Patients and carers
    - Caldicott Guardian
    - Staff or directors responsible for:
        - Clinical governance
        - Patient advice and liaison service (PALS)
        - Quality improvement
        - Strategic planning
- **Involve the person responsible for drawing the patient sample** in planning meetings. It is essential that this person, and their line manager, understand the purpose of the survey and the importance of drawing the sample correctly.
- **Keep everyone informed.** Notify as many people as possible about ideas and activities. All departments in the trust that have contact with patients should be made aware when a survey is being conducted, in case patients ask questions.
- **Do not overlook front-line staff**, who have the most frequent direct contact with patients. Staff can become nervous and defensive if they are not formally told about a patient survey. These feelings can compromise the effectiveness of the survey and increase resistance to any negative feedback.

3 Approved Survey Contractor versus in-house surveys

Trusts may choose to carry out their surveys in-house, or to commission an Approved Survey Contractor to carry out the work for them. Generally speaking, it is not advisable to carry out large-scale surveys in-house if you do not already have experience in carrying out surveys. Tracking large surveys with appropriate follow-up is an administratively complex task requiring dedicated resources for several months. Getting systematic feedback from patients requires money, resources and staff time. Considering the following questions can help you decide whether it makes sense for your trust to conduct the survey in-house or to commission an Approved Survey Contractor:

- Costs
- Quality and confidence in the findings
- Timing
- Human resources
- Comparing departments or hospitals within your trust

3.1 Costs

The financial resources needed to carry out a survey in-house are often under-estimated. The following is a list of the main items of expenditure for a postal survey, including the two reminders that must be sent out for all NHS Trust Surveys.

Staff time

This is one of the largest expenditures, but it is sometimes overlooked. Be sure to factor in the cost of staff time, including salary and fringe benefits, and time spent away from other work.

Materials

Stationery and postage

You will need to cover stationery and postage for three mailings. The first mailing will go out to 850 patients and second and third mailings will be sent only to non-responders. (See Section 11 – Materials for more details.) You will also need to cover the cost of second class postage for three mailings, two of which will be greater than the standard letter rate, while the second mailing (first reminder slip) will be standard letter rate.

FREEPOST licence

The FREEPOST address can be printed on return envelopes so that respondents can send back the survey at no cost to themselves. There is a charge for obtaining a FREEPOST licence. (For more details, see 12.1 - *Setting up a FREEPOST address*.)

FREEPHONE service

This service gives patients easy access to advice and staff can reassure them on any concerns they have about the survey. The cost of setting up the service and of staff time in responding needs to be considered.

Data entry

If the data are entered manually, you will need to allow enough staff time for this, and for checking the accuracy of the data file. Alternatively, a data processing or scanning company may be contracted to process the data. You will need to allow enough time for agreeing the details of a contract with a company and discussing their specific requirements (such as the size of the response boxes). If you use in-house scanning equipment, allow time for setting it up to read the data correctly from questionnaires.

Design and production of reports

This requires a considerable amount of skilled staff time.

3.2 Quality and confidence in the findings

Rigorous methodology is especially important if the data are to be used to compare experiences among groups of patients, to make precise estimates of problems or for Performance Indicators. A good survey provider will use methods that assure statistical validity and unbiased results.

Valid, credible comparisons can only be made using data that are collected with the same instrument, using similar methods. That is, by comparing like with like. All participating trusts should use the same sampling methods to ensure that you are comparing information about the same types of patients. Without such standardisation, comparative data will not be valid and reliable.

Since the results are to be used in a public forum, where their credibility might be questioned, it is advisable to hire an Approved Survey Contractor. Patients, too, might be sceptical about feedback that is collected by trusts themselves. Results that come from an independent source may be taken more seriously.

3.3 Timing

It is often possible to carry out small, localised surveys quickly in-house. However, even in the best of situations, other demands on staff can side-track them into other work. On the other hand, if you commission an Approved Contractor to carry out the survey, you should ensure that appropriate and realistic deadlines are set.

3.4 Human resources

In order to carry out a survey effectively, experience and/or skills in the following areas are needed:

- Administration of postal surveys
- Communication and coordination of multi-disciplinary teams
- Data entry, validation and cleaning
- Data analysis and interpretation, and familiarity with a statistical computing package
- Report writing.

3.5 Comparing departments or hospitals within your trust

If want to go beyond the minimum requirements, you could use the NHS Trust Survey programme as an opportunity to gather data about different units or hospitals within your trust. You could extend the number of patients you target, and ensure that you target sufficient numbers from each of the units you want to compare so that you can get enough responses to make comparisons.

Small limited surveys are easier for in-house administrative and volunteer staff to handle than are large surveys. You may wish to consider doing the large NHS Trust survey with an Approved Survey Contractor, and following it up with smaller, targeted in-house surveys.

Important note

If you choose to increase your sample size, it is essential that you ensure that the sample of patients you draw according to the requirements for the national survey can be easily distinguished from any additional patients you include in the sample. You will need to send only the data from the 850 patients sampled according to these guidelines to the Advice Centre.

When you have decided who will carry out your survey, you must inform the Advice Centre. The deadline for this is 31st October 2003.

4 Commissioning a survey from an Approved Contractor

The framework agreement set up by the Department of Health covers the core survey process. Approved Contractors are expected to provide the following services:

- Advising on sampling, providing support to trusts for sampling
- Printing questionnaires, covering letters, reminders and providing consumables
- Handling receipt of questionnaires, liaising with trusts re non-responses and reminders
- Support to ensure good response rates, e.g. FREEPHONE line
- Data entry, cleaning data and providing data to Survey Advice Centre by the deadline
- Preparing standard reports for trusts.

Fourteen organisations have been approved by the Department of Health to carry out the local NHS Trust Inpatient Surveys. Trusts may commission one of these contractors without further tendering for the survey work. Before committing to a contractor, you are advised to **check exactly what is covered** within the cost quoted.

Further information about each of these organisations, including their prices, can be found on the NHSSurveys website at

http//:www.nhssurveys.org

4.1 List of approved contractors

Ipsos-RSL

Contact: Sam McGuire

Head of Social & Public Sector Research
Ipsos – RSL
Kings House
Kymberley Road
Harrow
HA1 1PT
Tel: 020 8861 8703
Fax: 020 8863 0957
E-mail: sam.mcguire@ipsos.com

Maritz

Contact: Gavin Sugden

Associate Director
Maritz Research
Seagate House
Globe Park
Marlow
SL7 1LW

Tel: 01628 895 508
Fax: 01628 478 869
E-mail: gsugden@maritz.co.uk

Market Research UK

Contact: Craig Taylor; Jo Cleaver; Rachel Cope

Market Research UK
King William House
13 Queen Square
Bristol
BS1 4NT

Tel : 0117 987 2844 (South/South West/Midlands);
0207 388 5228 (London/South East/ East);
0161 234 0130 (North)
Fax : 0117 987 3385; 0207 388 8644; 0161 234 0129
E-mail: info@mruk.co.uk; london@mruk.co.uk; research@mruk.co.uk

Marketing Sciences

Contact: Eileen Sutherland

Marketing Sciences
8 Clement Street
Winchester
Hants
SO23 9DR

Tel: 01962 842211
Fax: 01962 840486
E-mail: esutherland@marketing-sciences.com
Website: http://www.marketing-sciences.com/

Market & Opinion Research International (MORI)

Contacts: Tim Jennings, Mark Gill

MORI Health Research,
Market & Opinion Research International (MORI),
79-81 Borough Road
London
SE1 1FY

Tel: 020 7347 3000
Fax: 020 7347 3800
E-mail: tim.jennings@mori.com; mark.gill@mori.com
Website: http://www.mori.com

MSB Ltd

Contact: Stephen Harwood

MSB Ltd
Winslow House
Ashurst Park
Church Lane
Sunninghill
Ascot
Berkshire
SL5 7ED

Tel: 01344 876 300
Fax: 01344 873 677
E-mail: stephen.harwood@msbconsultancy.com
Website: www.msbconsultancy.com

NFO System Three

Contact: Carys Alty
Wembley Point
Harrow Road
Wembley
Middlesex
HA9 6DE

Tel: (020) 8782 3000
Fax: (020) 8900 1500
Email: carys.alty@nfoeurope.com
Website: nfoeurope.com

NOP

Contacts: Richard Glendinning, Tim Buchanan, Claire Ivins or Sarah McHugh

NOP Social and Political
Ludgate House
245 Blackfriars Road
London
SE1 9UL

Tel: 020 7890 9000 (Switchboard)
Fax: 020 7890 9744
E-mail: r.glendinning@nopworld.com; t.buchanan@nopworld.com; c.ivins@nopworld.com; s.mchugh@nopworld.com

Website: http://www.nop.co.uk

ORC International

Contact: Geraldine Bailey

Account Manager
Public Sector Research
ORC International
Angel Corner House
1 Islington High Street
London
N1 9AH

Tel: 020 7675 1066
Fax: 020 7675 1908
E-mail: geraldine.bailey@orc.co.uk; patientsurvey@orc.co.uk

Patient Dynamics

Contact: Andrew Smith

PatientDynamics™
Riverside House
5 Nutfield Lane
High Wycombe
Buckinghamshire
HP11 2ND

Tel: 01494 536346
Fax: 01494 536146
E-mail: andrew.smith@patientdynamics.org.uk

Picker Institute Europe

Contacts: Stephen Bruster, Bridget Hopwood, Tim Markham or Nick Richards

Picker Institute Europe
King's Mead House
Oxpens Road
Oxford
OX1 1RX

Tel: 01865 208100
Fax: 01865 208101
E-mail: surveys@pickereurope.ac.uk
Website: www.pickereurope.org

PricewaterhouseCoopers

Contact: Dave Ingram, National Project Coordinator – Patient Surveys

PricewaterhouseCoopers
Erskine House
68-73 Queen Street
Edinburgh
EH2 4NH

Tel: 0131 260 4101
Fax: 0131 260 4008
E-mail: dave.ingram@uk.pwcglobal.com
Website: http://www.pwchealth.com/

Quality Health

Contact: Dr Reg Race

Quality Health
Sutton Manor
Palterton Lane
Sutton Scarsdale
CHESTERFIELD
S44 5UT

Tel: 01246 856263 or 851143
Fax: 01246 851143
Email: QHConsult@aol.com
Website: www.quality-health.co.uk

Taylor Nelson Sofres

Contact: Susannah Quick or Christine Jamieson

Taylor Nelson Sofres
Holbrooke House
34 – 38 Hill Rise
Richmond
Surrey
TW10 6UA

Tel: 020 8332 8551/8557
Fax: 020 8332 1090
Email: susannah.quick@tnsofres.com or Christine.jamieson@tnsofres.com
Website: http://www.tnsofres.com

4.2 Contracts

In addition to standard contractual terms and conditions, the contract should specify the following:

- The groups, and numbers, of patients to be surveyed.
- The survey methodology (i.e. postal questionnaire with two reminders to non-responders).
- Exactly what the survey provider and the trust are responsible for in carrying out the survey project.
- The main person at the survey provider and the person at the trust responsible for managing the project.
- A timetable showing the dates on which each task is to be carried out and by whom.
- Copies of the questionnaire(s) to be used.
- The outputs of the project. That is, types of and numbers of reports to be delivered and details of any presentations to be carried out by survey contractors.
- The costs and a payment schedule.

5 Data protection and confidentiality

You will need to ensure that you comply with the Data Protection Act 1998, and that patient responses are kept confidential. You will also need to take care that you meet any guarantees of anonymity or confidentiality made in covering letters and on the questionnaire form. Your trust's Caldicott Guardian will be able to advise you on matters of data protection.

5.1 Caldicott

Each NHS Trust has a Caldicott Guardian who is responsible for overseeing proper use of patient data. They have to ensure that any use of patient data conforms to the following principles:

- **Principle 1** - Individuals, departments and organisations must justify the purpose(s) for which information is required
- **Principle 2** - Don't use patient-identifiable information unless it is absolutely necessary
- **Principle 3** – Use the minimum necessary patient-identifiable information
- **Principle 4** - Access to patient-identifiable information should be on a strict need-to-know basis
- **Principle 5** – Everyone should be aware of their responsibilities
- **Principle 6 -** Understand and comply with the law

Further information about the use of patient information and the Data Protection Act can be found at:

http://www.doh.gov.uk/dpa98/

5.2 Sending out questionnaires

To comply with the Data Protection Act, NHS trusts should not release the names, addresses and other personal details of patients to anyone who is not employed by the trust. This includes releasing names and addresses for the purpose of mailing questionnaires to patients.

If you commission an Approved Survey Contractor to carry out the survey, there are two common methods currently being practised by trusts working with contractors:

1. The contractor delivers pre-packed serial-numbered envelopes containing questionnaires, covering letters and FREEPOST envelopes to the trust. The trust then attaches number-matched address labels to the envelopes and sends them out to patients. Completed questionnaires can then be returned to the contractor and, by checking the Record Numbers on returned questionnaires, they can inform the trust which patients need to be sent reminders. This process is described in more detail in Sections 9 and 12.

2. Alternatively, with the agreement of the trust's Caldicott Guardian, you may set up an *honorary contract* between the trust and one or two people who are already employed by the external contractor. Those people then become unpaid employees of the trust (while continuing to be employees of the external contractor) during the period in which the survey is carried out. It is then permissible for the contracted employee to be given patient contact details for the purposes of sending out questionnaires and reminders to patients. The external contractor must be registered under the Data Protection Act and appropriate steps must be taken to protect patient confidentiality. A sample honorary contract is shown on the following page.

5.3 Points to remember

- The amount of patient information handed over to the contractor should be kept to a minimum.

- The patient information should be password-protected, and the password should only be known to one individual in the trust who sends out the information and one or two people from the external contractor who receive the information.

5.4 Sample Honorary Contract

[Name of NHS Trust]

To: [Name of employee] **[Date]**

1. We are pleased to offer you an honorary (unpaid) appointment with this Trust. The appointment is to enable you to carry out the necessary operations and procedures that will enable this Trust to participate in the NHS Patient Surveys.
2. The period of appointment covered will be from [1st date] to [2nd date]. However, your work during this period will be part-time and intermittent, and may well be complete before the end of the period.
3. Similarly the pattern of hours worked in any week will vary according to the requirements of the survey procedures. The number and distribution of hours will be a matter for mutual agreement between you and [name of external contractor]. You will of course be covered by the Working Time Regulations 1998 and will not be expected to follow other than standard procedures in respect of working time.
4. The work will be carried out off-site at a location to be agreed with [name of external contractor].
5. Since the appointment is unpaid, this contract carries no entitlement to paid holidays, bank holidays, sick pay etc. Your entitlements in these respects will be the responsibility of [name of external contractor] which is the organisation responsible for the overall design, conduct and reporting of the NHS Patient Survey.
6. It will be expected that you carry out your work in a manner which is safe and absent from risk to your own health and that of any other person who may be affected by your actions or omissions. It is also expected that you will co-operate with the Trust in complying with any relevant statutory regulation imposed by the Trust. Whilst on Trust premises you must comply with the requirements of the Health & Safety at Work Acts 1974 (including Regulations and Codes of Practice issued thereunder).
7. During the course of your work you may have access to information concerning the Trust's staff, policies, finances or patients, which is strictly confidential. It is a condition of your appointment that in no circumstances will such information be passed on or discussed with any unauthorised person. A breach of confidentiality during this contract would result in its termination.
8. It follows from the above that any confidential information and data for which you are responsible should be kept under continuous review and stored in secure circumstances when it is off-site. The data will be disposed of in a safe manner, and any patient details will be destroyed before disposal.
9. If required to work on the Trust premises the Trust cannot accept responsibility for articles of personal property lost or damaged on their premises whether by burglary, fire, theft or otherwise. You are therefore advised to cover yourself in this respect against all risks.
10. Notwithstanding the above, for the purpose of employment insurance (and for no other purpose) you will be regarded as a Trust employee during the proper performance of your duties, provided that at all times you exercise all reasonable skills and judgement and always act in good faith.
11. Please sign and return this letter by way of confirmation of your agreement to the terms on which the appointment is made.
12. The offer and the acceptance of it should together constitute a contract between two parties.

FORM OF ACCEPTANCE

I hereby accept the terms and conditions set out above.

Signed: …… Date:……..

[Name of employee]

Signed: … …… Title: ……..
(On behalf of the Trust)

[NHS Trust]

13. Date:……..

5.5 Patient confidentiality

It is essential that any patient survey is conducted in such a way that respects patient confidentiality. That is, patients must be assured that doctors, nurses and other healthcare workers will not be able to identify individual patients' responses. Furthermore, their responses must not be presented to anyone in a way that allows individuals to be identified. For example, if a patient is known to have stayed on a particular ward, and his or her age, sex and ethnic group are known from their survey responses, it might be possible to use this information to identify them. We would recommend that patient responses should be aggregated into groups of no less than 30 patients before data are presented to staff.

5.6 Patient anonymity

In-house surveys

It is important to ensure that any claims you make about patient anonymity are accurate. In most cases where a survey is carried out in-house, it is not accurate to tell patients that their responses will be anonymous. The person who receives the completed questionnaires is usually able to match these responses to patient names and addresses.

Approved Contractors

Patient anonymity can sometimes be achieved if there is a clear separation between the information seen by an approved contractor and the information held by the trust. Patients' names and addresses should be seen by trust staff only, while individual patient's responses should be seen by contractor staff only. As long as the response data supplied to trusts do not include Patient Record Numbers and are not provided to trusts in a way that allows individuals to be identified, it can reasonably be claimed that patients' responses are anonymous.

5.7 Storing completed questionnaires

Completed questionnaires must be stored in a separate location to lists of patients' names. Similarly, the electronic file containing the patients' names and addresses should be stored on a separate computer to that containing the survey data.

Any mailing lists of patients' names and addresses should be deleted or destroyed as soon as the mailing process is complete. However, when you destroy the name and address information, remember to keep the other information held in the same file (such as age, sex and survey number) since this will be needed later.

6 Ethical issues, ethics committees and research governance

Research Ethics Committees provide independent advice to participants, researchers, care organisations and professionals on the extent to which proposals for research studies comply with recognised ethical standards. The purpose of Research Ethics Committees in reviewing a proposed study is to protect the dignity, rights, safety, and well-being of all actual or potential research participants. They will also seek reassurances regarding issues such as data protection, confidentiality and patient anonymity, and they will want to check that proposed research projects will not cause physical or mental harm to patients.

6.1 Ethical approval for the inpatient survey

Multi-Centre Research Ethics Committee (MREC) approval has been obtained for the Core Questionnaire, the question bank, the covering letters and the reminder letters, all of which can be downloaded from the NHSSurveys website. In order to comply with the ethical approval, the survey must be carried out according to the guidelines set out in this document.

You do not, therefore, need to seek ethical approval for this survey, unless you design your own additional questions. However, you should inform the relevant LREC(s) and/or send them a copy of the MREC approval letter. You do not need to wait for confirmation or approval from the LREC before starting your survey. The MREC letters can be downloaded the NHSSurveys website. Note that there are different documents, depending on whether you use only the pre-approved questionnaire and question bank, or if you choose to add new questions or change the methodology (see below).

6.2 Adding your own questions

If you write your own questions, you will need to obtain ethical approval from the Local Research Ethics Committee (LREC) before you proceed. The LREC will want to see the letter from the MREC and any additional documents relating to the changes you intend to make. This process may take at least 2 months.

6.3 Further information on ethical approval

Further information on the ethical approval process can be found at www.corec.org.uk/LRECContacts.htm or by e-mailing queries@corec.org.uk.

6.4 Research governance requirements

The Research Governance Framework aims to ensure that health and social care research is conducted to high scientific and ethical standards. It spells out standards and responsibilities of various parties involved in the research. One of the main purposes of the framework is to reduce unacceptable variations in research practice.

The Commission for Health Improvement (CHI), as sponsor of this national survey, has taken steps to ensure that principles of research governance and ethics are followed thoroughly. A standard core questionnaire and guidance notes are an important step in ensuring that the survey is carried out by all trusts in the same way without any variations.

The development of the survey, covering letters to patients, and the questionnaire as well as the bank of questions have all been approved by a multi-centre ethics committee. The questionnaire and guidance notes on how to conduct the survey are produced by the NHS Patient Survey Advice Centre who are guided by peer reviewed research evidence available in this area.

CHI has detailed arrangements in place for the management and monitoring of the surveys. Trusts and approved contractors are also required to set up a helpline for patients so that they can call with any questions.

The Department of Health has confirmed to CHI that it would be inappropriate for individual trusts to follow the same local research governance processes as they would if the survey were a study the trust is to sponsor. As this national patient survey has multi-centre research ethics committee approval and CHI takes responsibility for it as sponsor, this would duplicate work and delay implementation unnecessarily.

Trusts are invited to give permission for the surveys to go ahead after confirming they have the local research governance arrangements to support this type of study.

References

Research Governance Framework for Health and social care, Department of Health 2001

Research Governance Framework for Health and social care (Draft), Department of Health 2003

The following table has been prepared by the Commission for Health Improvement. It is taken from Section 3.10 of the *Research Governance Framework for health and social care.* The left-hand column sets out the responsibilities of organisations providing care and the right-hand columns sets out the arrangements made by CHI for this survey. If you are required to seek approval from your research governance lead, you are advised to present this information to your R&D Manager in support of your request.

Responsibilities of organisations providing care

Research Governance Framework	**CHI patient surveys**
Retain responsibility for the quality of all aspects of participants' care whether or not some aspects of care are part of a research study.	*The survey is carried out on the experiences of patients after they have received the care so this does not apply.*
Be aware and maintain a record of all research undertaken through or within the organisation, including research undertaken by students as part of their training.	*All Chief Executives are informed of the proposals of the survey. Similar letter has been sent to the R&D Managers of the trusts.*
Ensure patients or users and carers are provided with information on research that may affect their care.	*The survey does not affect the care of the patients. Anonymised results are used for performance rating and local quality improvement initiatives. Detailed guidance is issued to survey leads regarding the publicity of the results and its impact on patient care.*
Be aware of current legislation relating to research and ensure that it is implemented effectively within the organisation.	*This requirement is not specific to this survey.*
Ensure that all research involving participants for whom they are responsible has ethical approval and that someone with the authority to do so has given written permission on behalf of the care organisation before each study begins.	*CHI as sponsors of the study have sought ethics approval from MREC.* *There is a designated lead for each survey who is appointed by the Chief Executive.*
Ensure that no research with human participants, their organs, tissue or data, begins until an identified sponsor, who understands and accepts the duties set out in this framework, has confirmed it accepts responsibility for that research.	*CHI as sponsors have undertaken steps to ensure that all the duties of the sponsors listed in section 3.8 of the Research Governance Framework are followed thoroughly.*
Ensure that written agreements are in place regarding responsibilities for all research involving an external partner, funder and/or sponsor, including agreement with the University or other employer in relation to student supervision.	*A detailed guidance is issued to all the trusts, which spells out the responsibilities of all parties involved in the survey.*

Maintain the necessary links with clinical governance and/or best value processes.	*The guidance notes very strongly recommend the trusts to maintain these links and follow best practice evidence.*
Ensure that, whenever they are to interact with individuals in a way, which has a direct bearing on the quality of their care, non-NHS employed researchers hold honorary NHS contracts and there is clear accountability and understanding of responsibilities.[1]	*In situations where trusts opt to use the services of an external contractor to draw the sample for the survey, the contractor is required to enter into an honorary contract with the trust. These procedures are specifically detailed in the guidance notes.*
Put and keep in place systems to identify and learn from errors and failures.	*CHI also undertakes consultations with the trusts in order to ensure that the errors and failures are reported back to CHI. The survey programme is constantly evaluated and reviewed in the light of these.*
Put and keep in place systems to process, address and learn lessons from complaints arising from any research work being undertaken through or within the organisation.	*This requirement is not specific to this survey.*
Ensure that significant lessons learnt from complaints and from internal enquiries are communicated to funders, sponsors and other partners.	*CHI maintains a helpline facility, which can be used by patients or trusts to report any complaints. Similar arrangements are in place with the NHS Patient Survey Advice Centre who are commissioned by CHI to co-ordinate the patient surveys.*
Ensure that any research-related adverse events are included in reports to the National Patient Safety Agency in line with the standard procedures of the organisation; or to the systems for adverse events reporting in social care.	*Not applicable to the patient survey. Patient safety is not compromised, this being a postal survey.*
Permit and assist with any monitoring, auditing or inspection required by relevant authorities.	*The results of the surveys are used for performance monitoring and national star rating mechanisms*

[1] When universities and hospitals employ staff on joint or dual contracts, they are expected to make joint arrangements for accountability and management. See *A Review of Appraisal, Disciplinary and Reporting Arrangements for Senior NHS and University Staff with Academic and Clinical Duties*, a report to the Secretary of State for Education and Skills by Professor Sir Brian Follett and Michael Paulson-Ellis, September 2001 (The Follett Report).

7 Collecting data from non-English-speaking populations

The patients who respond to your survey should be representative of all of the patients who use the trust, so it is important that groups with limited understanding of English are not excluded. The Core Questionnaire and the question bank have been written in as **simple language** as possible to facilitate optimum understanding by all respondents. The questions have also been tested with patients from a range of ethnic groups. For this survey, translated questionnaires are not being used. We do not recommend translation of questionnaires as the most effective way of obtaining feedback from minority language groups in postal surveys such as these. In considering this issue, it is worth noting the following points:

- It will be difficult or impossible to identify non-English-speaking patients or their specific language from patient records before questionnaires are sent out because language spoken is not usually included on patient administrative systems. Therefore, the first contact with them will have to be in English.

- It might be appropriate to use **alternative data collection methods** to assess the experiences of non-English-speaking patients, or patients whose literacy levels are low. For example, it may be easier for some groups to report their experiences in focus groups or face-to-face interviews.

- The Commission for Health Improvement are carrying out further work to assess the options for seeking the views of ethnic minority groups. If you would like further information or would like to offer feedback on this topic, please contact Dr Rekha Elaswarapu at CHI: rekha.elaswarapu@chi.nhs.uk.

There are a number of strategies you can adopt to facilitate the process of collecting ethnic minority views within this survey:

- You could include a **multi-language leaflet** with the first mailing, offering help or translation services to those who might require it.

- You could offer patients whose spoken English is better than their written English the option of **completing the questionnaire over the telephone**, using a FREEPHONE line.

- Consider subscribing to a specialist interpreting service. Your trust may already be in touch with one in your area. Alternatively, you could use a national service, such as **Language Line.** (See http://www.languageline.co.uk, e-mail info@languageline.co.uk or call 020 7520 1430.) Telephone interpreting services in around 100 languages are offered on a pay-as-you-go basis. If required, a three-way conversation can be set up between you, the patient and the interpreter.

- Many households include at least **one competent English speaker** who can help the patient to fill in a questionnaire. In practice, this is often the most efficient way of gathering data from non-English-speakers, although it is not ideal, as there is no control over the way in which a patient's family or friends translate questions or interpret their responses, and it does not allow the patient to answer the questions for themselves.

8 Timetable

The length of time taken to complete the survey process will depend on many factors. Assuming no delays, it is reasonable to allow about 12 weeks from start to finish. Dissemination of the results to all staff will take considerably longer. This timetable is based on the *minimum* expected duration of each stage. If you commission an Approved Contractor, most of the work will be done by them, but you will still have to be involved in some of the stages of the process, marked in **bold** in the timetable below.

Week	Task	See Section
1	**Inform Survey Advice Centre about who is carrying out the survey (by 31st October 2003 at the latest).**	3
1	**Decide on questions to be included in the survey (i.e. select from question bank) or use the Core Questionnaire**	10
1	**Draw sample of patients to be included in the survey**	9
1	**Submit sample list to Tracing Service to check for deceased patients**	9.4
1	**If using an approved contractor, supply them with trust headed paper and a signature of a senior executive and, if appropriate, ensure that the honorary contract is signed**	5.2 5.4&11.2
1	Print questionnaires and covering letters. Ensure you have enough headed paper, envelopes, return envelopes and labels	11
2	Set up FREEPOST address and FREEPHONE line	12.1&12.2
2	Establish system for responding to telephone enquiries	12.2
3	Establish system for booking in questionnaires	12.5
3	**Check your own trust's records again for any patient deaths**	9.5
3 - 8	**Stick labels on pre-packed numbered questionnaires supplied by approved contractor (if not using honorary contract)**	12.4
3	Send out first questionnaires	12.4
3 - 12	Continue to respond to telephone enquiries	12.2
3 - 12	Continue to book in returned questionnaires	12.5
3 - 12	Enter data	13
5	Check your own trust's records for any patient deaths	9.5
5 - 6	Send out first reminders to non-responders	12.6
5 - 6	Be prepared for a small peak in telephone calls as first reminders received	12.2
8	Check your own trust's records for any patient deaths	9.5
8	Send out second reminders to non-responders	12.6
11	Complete data entry	13
11	Check data for errors ***Very Important***	13.4
12	Send data to Survey Advice Centre (by 31st March 2004 at the latest)	14&15
12	Begin analysing trust's results and writing report	15
13 -	Disseminate results to staff, patients and the public	16

9 Compiling a list of patients

This section explains how to draw the sample of patients. This task will need to be carried out by a member of staff at the NHS Trust.

N.B. It is essential that the person who draws the patient sample understands the importance of following these instructions carefully. Also, that person's line manager must give them the time and support they need do to the task properly.

We advise that you read all of this section before you start to compile your patient list.

In acute trusts, the sample will normally be drawn from the Patient Administration System (PAS). Prior to sending out questionnaires, the list will also have to be checked for deceased patients by the NHS Strategic Tracing Service (NSTS).

9.1 Compile a list of eligible patients

- Select the month of inpatient discharges that your survey will cover. Depending on when you start, this should be **either** September 2003 **or** October 2003 **or** November 2003. (December should be avoided, as it tends to be atypical.) [2]

- Compile a list of 900 [3] adult inpatients consecutively discharged alive from your trust leading up to the last day of the sampling month. That is, once you have decided on the latest date of patient discharge you will include in the sample (i.e. 30 September, 31 October OR 30 November), you should count back through the list, including all eligible patients until you have 900 patients.

- The information you obtain about each patient will be used both for administering the survey and for sending to the tracing service to check for deceased patients. It saves time and effort if all the information is gathered at the same time.

- The list should **not** include deceased patients, children or young persons aged under 18, maternity patients, psychiatry patients, patients admitted for termination of pregnancy, day cases, private patients, current inpatients, or patients without a UK postal address.

- Note that the list should include **all** eligible adult patients, who have had at least one overnight stay within the trust.

---

[2] Note that your discharge dates may not cover the entire month, or may cover more than one month. This will depend on the volume of patients treated at your trust. Large trusts will have a sample that covers only a few days of discharge dates, while small trusts may have discharge dates that span several months.

[3] The final sample size must be no greater than 850, but this allows for some extra patients, once any deceased patients have been taken out of the sample.

9.2 Checks on the patient list

Once you have compiled your list of 900 patients, you should carry out the following checks before you send to the NSTS to carry out a further check for deceased patients.

- **Deceased patients.** Check that the patients were all discharged alive. Also check that the trust does not have a record of a patient's death from a subsequent admission or visit to hospital.
- **Overnight stay.** Check that patients had at least one overnight stay in hospital. Day cases and outpatients are **not** included in this survey.
- **Current inpatients.** Check again that none of the patients are known to be current inpatients in your trust (or elsewhere, if known).
- **Patient ages.** Check again that all patients are aged 18 or over.
- **Postal addresses.** Exclude any addresses that are outside the UK.
- **Incomplete information.** Eliminate patient records with incomplete information on key fields (such as surname and address). However, do not exclude anyone simply because you do not have a postcode for them.
- **Duplications.** Check that the same patient has not been included more than once.
- **Maternity patients**. Check again that the list does not include maternity patients.
- **Psychiatry patients**. Check again that the list does not include psychiatry patients.
- **Private patients.** Remove any private patients from the sample.
- **Patients treated at private hospitals.** Remove any patients who were treated by the trust as NHS patients in private hospitals.
- Check again that none of the patients was admitted for a **termination of pregnancy.**

9.3 Data fields to include in the list of patients

You will need to keep the list in an electronic file in a programme such as Microsoft Excel or Access. The list should contain the following information:

- Title (Mr, Mrs, Ms, etc.)
- Initials (or First name)
- Surname
- Address Fields [4]
- Postcode
- Year of birth
- Gender
- Ethnic group [5]
- **Day** of the month of discharge (1 or 2 digits; e.g. 2 or 30)[6]
- **Month** of discharge (1 or 2 digits; e.g. 9 or 10)
- **Year** of discharge (4 digits; e.g. 2003)
- Any other details required by the NHS Strategic Tracing Service (NSTS). [7] Wherever possible, this should include the NHS number.
- Hospital or unit (optional)[8]

---

[4] The patient address should be held as separate fields (e.g. street, area, town, county, postcode). This should be consistent with the address format required by the NSTS.

[5] It is acknowledged that patient records might not always contain complete data on patients' ethnic group. However, this field should be included wherever possible. This data is required in order to evaluate non-response from different ethnic groups. This is in keeping with the aims of CHI and Department of Health to be more responsive to all ethnic groups and provide services that take account of their individual requirements.

[6] This year, we are asking you to supply the date fields in separate columns. The purpose of this is to overcome the problems of trusts supplying dates in differing formats in Excel.

[7] The NHS number can give more accurate matching, especially if addresses are incomplete. It is advisable to liaise with the registered NSTS batch trace user (if this is not the same person who creates the sample list) to ensure that all the required fields are extracted when compiling the list of patients (see Section 9.4 for more details on using the NSTS).

[8] If you plan to compare hospitals or units within your trust, it is important to bear in mind that it is not sensible make comparisons based on small sample sizes, as you are unlikely to obtain accurate measures of patient experience. We would recommend comparing groups no smaller than 200-300 patients.

9.4 Submit the sample list to the NHS Strategic Tracing Service (NSTS)

Before sending out the questionnaires, the list of patients will also have to be checked for any deceased patients by the NHS Strategic Tracing Service (NSTS).

The NSTS contact details are as follows:

Help desk telephone number: 0121 788 4001

Website: http://nwww.nhsia.nhs.uk/nsts/

The time required to carry out the checks depends partly on the compatibility of the list you submit to the NSTS with their system requirements. To avoid any delay, check carefully that your list is in the correct format for NSTS.

The file returned from NSTS can be used to identify the records that need to be deleted from the sample file. This will reduce the numbers in the sample list slightly.

Note

Please be aware that tracing services are not fool-proof and even after your patient list has been checked for deaths, some patients may die in the period between running the check and the questionnaire being delivered. You may find that some recently deceased patients remain in your sample. You need to be prepared for this. Special sensitivity is required when dealing with telephone calls from bereaved relatives.

9.5 Check the trust's records for patient deaths

One of the most reliable and up-to-date sources of information on patient deaths is your own trust's records. It is essential that you check that your trust has no record of a patient having died at your trust. Relatives are likely to be particularly offended if they receive a questionnaire or reminder from the trust where their relative died. Clearly, patients may also have died at home or while under the care of another trust, so you still need to check with the tracing service as well. You are also advised to repeat this check before the second and third mailings, and to ensure that approved contractors are advised of any patient death that occurs during the survey period.

Note from SchlumbergerSema (NSTS Partner)

Within your trust, there should be a "Caldicott Guardian delegated authority", who is the person authorised to send batch traces to the NSTS. You should ask this person to submit the batch trace request for the patient survey, as SchlumbergerSema will only accept submissions from this person.

The format of the patient survey files and accompanying paperwork must be identical to that submitted by trusts on a regular basis for NHS number tracing.

The full details are given in the new instruction manual:

SchlumbergerSema NHS Patient Survey File Creation Guide

This is available on the NHSSurveys website.

The basic requirements are:

- The file must contain all 27 fields listed in Appendix D of the NSTS manual, even if they contain no data.
- No column headings must be included.
- The file can be either in fixed length or Comma Separated Variable (CSV) format. CSV is more popular and easier to create.
- File must be able to be opened in Notepad or similar text editor.
- Excel spreadsheets are not permitted.
- It is advisable to send a spare tape or disk with your batch trace, so that the tracing service can record their results on that, rather than having to delete your original file to re-use your original disk or tape. This will speed up the process.
- When the file is returned from the NSTS, the deceased marker can be found in field 32, where there would be a 3 digit Q-Code or a D (deceased).

Remember to keep a copy of the file you send to NSTS!

9.6 Reduce the list to 850 patients

When your patient list comes back from NSTS, there should still be more than 850 patients in the list. You will therefore need to **remove the least recent** patients from your list so that only the 850 most recent patients remain in the list.

Important note

You are aiming for **a response rate of at least 60%**, which means that you should have about 500 completed questionnaires if you send questionnaires to 850 patients. You will be able to maximise your response rate by following this guidance carefully, and you will need to send out three reminders. It is **not** acceptable to try to boost the number of responses you receive by sending out questionnaires to a larger number of patients. The Advice Centre will only be able to accept responses from the 850 patients in your list that have been correctly sampled.

9.7 Organise the patient information into the sample file

Once the file is returned from the NSTS, you will need to keep the patient information in an electronic spreadsheet or database file, where you can record which questionnaires have been returned. At the end of the survey process, you will be asked to send an anonymised version of this information to the Patient Survey Advice Centre.

Firstly, you will need to add three new columns:

1. **Patient Record Number.** This field will be a series of consecutive numbers (for example, 1001 through to 1850 but make sure it is a different number range from that used in your Paediatric Survey).

2. The **Outcome** field will be used to record which questionnaires are returned to the freepost address, or are returned undelivered, or which patients opt out of the survey, etc.

3. The **Comments** column is useful for recording any additional information that may be provided when someone calls the FREEPHONE to inform you that the respondent has died or is no longer living at this address.

Table 1 shows part of an example Excel file comprising patient details. Only the fields headed *in red italics* need to be included in the file sent to the Patient Survey Advice Centre.

Table 1 – Sample Excel file of patient details

Patient Record Number	Title	Initials	Surname	Address1		Address5	Postcode	*Year of birth*	*Gender*	*Ethnic Group*	*Day of discharge*	*Month of discharge*	*Year of discharge*	*Outcome*	Comments
1001	Mrs	AM	Abbot		--		AB1 1YZ	1934	2	1	2	9	2003	3	Informed patient died
1002	Mr	EC	Ahmed		--		AB2 6XZ	1970	1	3	14	9	2003	1	
					--										
1849	Miss	K	Yoo		--		AB4 7MX	1950	2	5	21	9	2003		
1850	Ms	F	Young		--		AB9 5ZX	1946	2	1	30	9	2003	1	

Notes on Table 1

- **Patient Record Number.** This number is unique for each patient. It can be seen in the example that the numbers are in ascending order, starting at 1001 at the top of the list, through to 1850 at the bottom. The patient record number will be included on address labels and on questionnaires. Later, when questionnaires are returned (whether completed or not), you (or the Approved Survey Contractor) will be able to use these numbers to monitor which patients have returned their questionnaires and to identify any non-responders, who will need to be sent reminders. If an approved contractor is used, you will need to agree with them on the range of serial numbers that will be used for your patients.

- The **Patient Record Number, Title**, **Initials**, **Surname**, **Address** fields and **Postcode** are used for printing out address labels. You can use mail merge in a word processing package for this purpose.

- The **Year of Birth** is included (in the form NNNN), so that the ages of those patients who send back questionnaires can be compared with the ages of non-responders.

- **Gender** should be coded as 1 = male and 2 = female. However, be aware that other systems may use a different coding.

- **The Discharge Day, Month and Year** are recorded in separate columns and formatted as *general* or *numeric* (rather than as dates).

- **Ethnic Group** should be coded using the broad categories 1 = White; 2 = Mixed; 3 = Asian or Asian British; 4 = Black or Black British; 5 = Chinese; 6 = any other ethnic Group. These are *based on* the standard categories introduced by the NHS Information Authority from 1st April 2001, but if your trust is using these categories, the data will need to be re-coded to these numeric codes.

- The **Outcome** field should be coded as follows:

  1 = Returned useable questionnaire
  2 = Returned undelivered by the mail service or patient moved house
  3 = Patient died
  4 = Patient reported too ill to complete questionnaire, opted out or returned blank questionnaire
  5 = Patient was not eligible to fill in questionnaire
  6 = Questionnaire not returned (reason not known)

  Note that these codes have changed since the last survey.

  The outcome column is left blank at first if the survey has not been returned (so it can be seen that Miss Yoo has not yet returned her survey); 1 = returned useable questionnaire, (Mr Ahmed and Ms Young have returned their surveys); 3 = patient died (Mrs Abbott's relative called to say that she had died).

  If the survey is being carried out in-house by the trust, you can use the file containing the patient name and address details to record the outcome information. If you are working with an Approved Survey Contractor, you should supply them with a list of record numbers (but patient names and addresses should be removed), against which they can record the outcome codes.

  Remember, you should only have 850 patients in the list at this stage.

9.8 Sharing the patient sample file with an approved contractor

If you are working with an Approved Survey Contractor, but **not** using an honorary contract to share patients' name and address details, you should supply them with a version of the list shown in Table 1 (with names and addresses removed). The contractor can use this list to record the outcome codes, and you should ensure that the contractor is kept up to date with any information that comes directly to the trust about deaths, etc.

9.9 Using this file

This file has two purposes:

1. It will be used to keep a record of which patients have returned questionnaires so that reminders can be sent to them.

2. The anonymous data in this file (i.e. all the data **except** patient name and address information) will form part of the file that you will submit to the Advice Centre when the survey is completed.

For patient confidentiality reasons, **it is essential that you do not keep patient name and address details in the same file as their survey response data**. Therefore, you should match up the anonymised patient information file with the data file once your survey is completed.

Alternatively, you should keep two copies of this file, one anonymised and the other with patient name and address details, but you will need to ensure that the "outcome" information, about whether patients have responded, or why they have not responded, is accurate and up-to-date in both files.

10 The core questions and question bank

Each trust must include in their survey at least the 50 core questions. There is a pre-designed "Core Questionnaire" on the NHSSurveys website, which includes only these questions. In addition, by using the "Create your own survey" option on the website, you can include supplementary questions from a bank of validated questions. These questions will be inserted into the appropriate places within the Core Questionnaire, and the document will then be generated in pdf format, ready for printing.

There is also a facility to design your own questions and response options on the website.

In summary, there are three options for carrying out the NHS Inpatient Survey:

3. The **Core Questionnaire**, which comprises 50 questions.

4. The **Enhanced Survey**, which includes all of the 50 core questions, with an additional bank of validated questions.

5. The **Customised Survey**, which is either the **Core Questionnaire** or the **Enhanced** Survey with additional new questions designed by you.

If you design your own questions, it is essential that survey questions be **carefully designed and properly tested** before they are included in a questionnaire. See Section 17 - *Appendix – Designing and testing new questions.*

You should also be aware that, if you include new questions, you will need to obtain **ethical approval** before proceeding with sending out questionnaires, as any new questions will not have been pre-approved by ethics committees.

The surveys can be accessed from the NHSSurveys website:

http://www.nhssurveys.org

10.1 The Core Questionnaire

The Core Questionnaire consists of 50 questions on 8 pages. These questions cover the issues that have been found to be most important to patients and they must be included in your survey. The front page of the survey explains the purpose of the survey and gives instructions on how to fill it in. In the following pages, the survey questions are divided into sections that broadly follow the patient's experience.

10.2 Using the question bank

The Core Questionnaire covers all the compulsory questions you need to ask for the NHS national survey programme. However, you might want to ask more questions on some topics, and you can do this by using the "Create your own survey" option on the website. The instructions on the website will guide you through the steps you need to take to create your own survey.

On this web page, you will notice that some questions have tick boxes next to them, while other questions do not. Those questions that have tick boxes are the optional questions, which can be selected or deselected from the question bank. The questions with no tick boxes (just bullet points) cannot be deselected because they are compulsory core questions, and they must be included in all NHS Trust Surveys.

As you select questions from the question bank, they are placed in the appropriate section on the survey form, so that the questionnaire flows sensibly. For example, if you add further questions about *Hospital environment and facilities*, they will be put into the section under that heading.

10.3 The Customised Survey

From the NHSSurveys website, there is also an option to include additional questions that you design yourself.

It must be emphasised, however, that it is not advisable to design new survey questions unless you have considerable experience in doing so. The time, effort, costs and skills required to design survey questions is very often under-estimated. For example, it is common for a single question to be re-worded ten or more times before it is considered acceptable. You would need to ensure that you have adequate time to carry out essential research with patients to check that questions are clear, appropriate and unambiguous. You may also need to seek approval from your Local Research Ethics Committee if you include new questions (See Section 6 - *Ethical issues, ethics committees and research governance*).

11 Materials

11.1 Printing questionnaires

Number of pages

It is practical to ensure that the number of pages in a questionnaire is a multiple of four so that sheets can be printed double-sided on A3 paper and folded to make an A4 booklet, stapled in the middle. If pages are stapled at the corner, there is a greater chance that some pages will become detached and get lost. The Core Questionnaire, available in pdf format on the NHSSurveys website, is designed to fit on to eight sides of A4 paper.

Number of questionnaires

When calculating the number of questionnaires to be printed, you will need to allow for sending out duplicate questionnaires as second reminders. Printing costs can be unnecessarily high if a second print-run is required, so it is worth ensuring that the first print-run is sufficiently large to allow for contingencies. As a rule of thumb, multiply the number of patients in the sample by 1.7 to obtain the number of questionnaires required. So, if the number of questionnaires you intend to send out is 850, then you might want to print 850 x 1.7, or approximately 1,500 copies.

11.2 Trust headed paper

You will need trust headed paper for covering letters for the first and third mailing. (A reminder slip is used for the second mailing.) Therefore, depending on your response to the initial mailings, you should need approximately 1,200 to 1,600 sheets of trust headed notepaper. If an approved contractor is being used to carry out the survey work, it is preferable that the paper does not include a telephone number for the trust, as patients should call the contractor's FREEPHONE line, rather than the trust.

11.3 Other items

You will also need:

- Large envelopes for mailing questionnaires to patient
- Labels for addressing envelopes
- Labels for sender address on reverse of envelopes
- FREEPOST envelopes for return of questionnaires

11.4 First mailing

You will need 850 of each of the following items:

- Printed questionnaires
- Large envelopes for mailing questionnaires to patient
- Labels for addressing envelopes
- Labels for sender address on reverse of envelopes
- FREEPOST envelopes for return of questionnaires
- Paper bearing the trust's letterhead for covering letters

11.5 Second mailing (first reminder)

First reminders are sent to all patients who do not respond to the first mailing (except, of course, those who withdraw). Usually, around 55-75% of the original patient sample need to be sent first reminders. The following items are needed:

- Reminder letters
- Envelopes
- Labels for addressing envelopes
- Labels for sender address on reverse of envelopes

11.6 Third mailing (second reminder)

The second reminder should include the same items as the first mailing, and will need to be sent to around 45-65% of the original sample, depending on the number of responses to the previous two mailings. The following items are needed:

- Printed questionnaires
- Large envelopes for mailing questionnaires to patient
- Labels for addressing envelopes
- Labels for sender address on reverse of envelopes
- FREEPOST envelopes for returning questionnaires
- Paper bearing the trust's letterhead for covering letters

12 Implementing the survey

This section gives guidance on administering the NHS Trust Inpatient Surveys using pre-designed surveys and pre-validated questions from the NHSSurveys website. The following topics are covered:

- Setting up a FREEPOST address
- Setting up a FREEPHONE line
- Covering letters
- Sending out questionnaires
- Booking in questionnaires
- Sending out reminders

12.1 Setting up a FREEPOST address

A FREEPOST address allows patients to return completed questionnaires at no cost to themselves. After you have paid for the licence, you will only pay for the responses you receive. The FREEPOST address can be printed on the envelopes you send out with the questionnaires. Printed envelopes must comply with Royal Mail guidelines. Details of how to apply for a FREEPOST licence can be found at the Royal Mail website:

http://www.royalmail.com

Or you can call your local Sales Centre on 0845 7950 950.

12.2 Setting up a FREEPHONE line

The covering letter to patients should include a telephone number for patients to call if they have any questions or complaints about the survey. All staff who are likely to take calls should be properly briefed about the details of the survey, and be aware of the questions or complaints they are likely to receive. If you run the survey in-house, you might want to set up a FREEPHONE line for this purpose. Alternatively, many Approved Contractors offer this service.

Common questions and comments

I have had two or more hospital admissions - which one should I refer to?

Patients should be advised to refer to their **most recent** hospital inpatient admission. Usually, this is the admission covered by your sampling period but, for the few patients who have been re-admitted since you drew the sample, it is simpler to tell them to refer to their most recent stay. It will not make the results invalid if a few of the patients refer to a more recent episode than the others.

I have a specific comment, complaint or question about my care or treatment. Who can I contact at the trust?

Patients can be referred to the trust's PALS, the complaints manager or patient services manager. Approved contractors should be given the contact details of the PALS office or an appropriate member of trust staff so that they can refer callers to that person.

The person to whom the questionnaire is addressed is unable to understand the questionnaire.

Relatives or carers may call to pass on this information. In some cases, they may offer to complete the questionnaire for the patient, but this is only advisable if they are likely to be able to give responses that are a true reflection of the patients' views.

The person to whom the questionnaire is addressed has died.

Even with the use of a deceased patients tracing service, it will not be possible to identify all deceased patients, particularly those who have died most recently. It is very important that staff who take the calls are aware of this possibility and are prepared to respond sensitively to such calls.

I would like to take part but English is not my first language.

If a patient's spoken English is better than their written English, they may be willing to have someone fill in a form on their behalf over the telephone. Alternatively, if your trust offers translation or interpreter services, participants could make use of these. For example, interpreters could read out the questions over the telephone in the patient's own language and record their answers on a questionnaire form.

I do not wish to participate in this survey.

A few patients might call to say that they do not want to be involved in the survey, and fewer still may object to being sent the questionnaire in the first place. Staff should apologise to the patient and reiterate the statement in the covering letter - that the survey is voluntary, and that the patient's care will not be affected in any way by their not responding. It might be helpful to point out the purpose of the survey, and to emphasise the potential value of the patient's responses. If the patient is willing to tell the staff member the identification number written on their survey, it might also be possible to prevent any further reminders being sent to that patient. It is also advisable to ask the patient to ignore any future reminders that they might receive.

Making a record of the calls

Where appropriate, ask the patients who call to tell you their Patient Record Number, which should be on the address label of the envelope they received, and on the questionnaire itself. You can then use this number to identify people who do not want to receive any further reminders.

It is useful to keep a record of the reasons patients called, as this can help to make improvements to future surveys and can provide useful additional information on patients' concerns. A standard form should be printed, so that the relevant details of each call can be recorded and survey organisers can monitor any problems and remove patients who wish to be excluded from the mailing list.

12.3 Covering letters

The following covering letter has been given ethical approval for use in the NHS Trust Inpatient Surveys. It should be printed on the trust's letterhead paper. A Word version is on the NHSsurveys website for you to download and add your own trust's details. If you make alterations to it, you will need to seek the approval of your Local Research Ethics Committee (LREC), and to check with the Advice Centre that your changes are acceptable. Two paper copies of the letter you use must be sent to the Advice Centre when you submit your data at the end of the survey.

Covering letter for first mailing

To be printed on Trust headed notepaper (ideally without trust telephone number if Approved Contractor is handling the FREEPHONE calls.) Text in square brackets needs to be edited.

[Date]

Dear Patient

Inpatient survey

We are trying to find out what patients at [Hospital A] or [Hospital B] of the [NHS Trust name] think of the care they receive. This survey is part of our commitment, outlined in the NHS Plan, to design a health service around the patient. The survey is being carried out by researchers from [NHS Trust name /name of survey company], the Commission for Health Improvement and the NHS Surveys Advice Centre at Picker Institute Europe. We are asking you to give us your views by filling in the enclosed questionnaire.

The questionnaire should only take about 20 minutes to complete. A FREEPOST envelope is enclosed. Your views are very important in helping us to find out how good the hospitals are and how they can be improved. This is your chance to have a say in how services are provided in the future.

Your participation in the survey is entirely voluntary. If you choose not to take part it will not affect the care you receive from the NHS in any way. If you do not wish to take part in the survey, or you do not want to answer some of the questions, you do not need to give us a reason. If you choose not to take part, please could you return the uncompleted questionnaire in the FREEPOST envelope provided and this will make sure you will not be contacted again. If we do not receive anything from you within three weeks, we may send you a reminder letter.

If you do decide to give us your views, you can rest assured that your answers will be kept confidential. No one outside the research team will be able to know which individual gave what answers. Information will not be passed on to doctors, nurses or other NHS health care staff in a form that allows you to be identified.

If you would like more information about the survey, or you have questions on how to fill in the questionnaire, you can call [our FREEPHONE help line /us] on [**phone number**] [at no cost to yourself]. The line is open between [opening time] and [closing time], [days] and we will try our best to answer any questions you may have.

Yours faithfully

[signature]

[print name of signatory]

12.4 Sending out questionnaires

Mailing labels

Three mailing labels are needed for each patient. One set of labels will be used for the first mailing, one for the first reminder and one for the second reminder.

We recommend using the mail merge feature in a word processing package to create the mailing labels from the database of patient names and addresses. **It is essential that the Patient Record Number is on each address label,** as this has to be matched with the questionnaire number.

Questionnaire packs

The envelope sent to each patient at the first mailing should include the following:

1. A questionnaire numbered with the Patient Record Number. The number on the address label must match the number on the list of patient details.
2. A covering letter.
3. A large envelope, labelled with the FREEPOST address on it.
4. These items should be packed into an envelope that has a return address on the outside. This should be the contact at the NHS Trust, or the Approved Contractor.

Postage

Note

The postage may exceed the standard letter rate. It is essential that the appropriate postage rate is paid.

Approved contractors – no honorary contract

If an approved contractor is carrying out most of the work, they should send pre-packed questionnaires to the trust for mailing out. The envelopes should be clearly marked with the Patient Record Numbers so that trust staff can match these with their patient list and put on appropriate patient address labels.

Approved contractors – honorary contract

If an approved contractor is carrying out the work under an honorary contract, they will send out questionnaires directly to patient, and the return address label will be the approved contractor's address.

12.5 Booking in questionnaires

When questionnaires are received, match up the Patient Record Numbers against the list of patients, so that you can record which patients have returned questionnaires and will not therefore need to be sent reminders. You will need to keep paper copies (or scanned pictures of the full questionnaires, including the front page) of any questionnaires that are returned to you until 31st August 2004, but please **do not** send these to the Advice Centre.

Approved contractors

If an approved contractor carries out the work, questionnaires will be returned directly to them, so they will be able to record these returns against the list of Patient Record Numbers. Trusts should inform the contractor of any questionnaires that were returned undelivered, and of any patients who inform the trust that they do not wish to be included in the survey, or if any patient dies during the period of the survey. The contractor can then record these details in their own patient list, and ensure that reminders are not sent out to those patients.

12.6 Sending out reminders

For results to be representative, it is essential to get a good response rate. The minimum response rate for the NHS Trust Inpatient Surveys is 60%. In order to achieve this, you will need to send out two reminders to non-responders.

After the first mailing, you can expect 30-45% of patients to have returned completed questionnaires within 2-3 weeks. First reminders should be sent out after 2-3 weeks and you can expect the percentage of returned questionnaires to rise by about 20%. The second reminder sent out after a further 2-3 weeks should bring the final proportion of returned questionnaires to 60-75%.

Depending on the time that has elapsed since you first checked your patient list for deaths, it might be necessary to send your list to the tracing service for a further check before you send out reminders. In any case, before sending out reminders you should check your own trust's records to check that there is no record of the patient's death in your own trust.

Working with approved contractors

When reminders are due to be sent out, survey contractors should send the pre-packed envelopes bearing the Patient Record Numbers of the non-responders. Again, the envelopes should be clearly marked with the Patient Record Number so that trust staff can match these with their patient list and put on appropriate address labels.

First reminders

Ethical approval has been obtained for the reminder letter printed below. It can be printed on A5. A Word version is on the NHSsurveys website for you to download and add your own trust's details. If you make alterations to it, you will need to seek the approval of your Local Research Ethics Committee (LREC), and to check with the Advice Centre that your changes are acceptable. Two paper copies of the letter you use must be sent to the Advice Centre when you submit your data at the end of the survey.

The first reminder should be sent to patients who have not responded after two to three weeks. This should be a short note.

First reminder letter

Text in square brackets needs to be edited

[Date]

[Name of NHS Trust]

Approximately two weeks ago we sent you a questionnaire about the care you received from [NHS Trust Name]. At the time of sending this note, we do not seem to have received a response from you.

Participation in the survey is voluntary, and if you choose not to take part it will not affect the care you receive from the NHS and you do not need to give a reason.

However, **your views are important to us** so we would like to hear from you. (The return envelope you were sent with the questionnaire does not need a stamp.)

If you have already returned your questionnaire – **Thank you**, and please accept our apologies for troubling you.

If you have any queries about the survey, please call [our FREEPHONE help line /us] on [**number**] between [opening time] and [closing time], [days], and we will do our best to answer any questions you might have.

Second reminders

Second reminders should be sent out after a further two to three weeks to patients who have not yet responded. The envelopes should include the following:

1. A questionnaire numbered with the Patient Record Number. The number on the address label must match the number on the list of patient details.

2. A covering letter.

3. A large envelope, labelled with the FREEPOST address on it.

The following covering letter has been given ethical approval for use in the NHS Trust Inpatient Surveys. A Word version is on the NHSsurveys website for you to download and add your own trust's details. It should be printed on the trust's letterhead paper. If you make alterations to it, you will need to seek the approval of your Local Research Ethics Committee (LREC), and to check with the Advice Centre that your changes are acceptable. Two paper copies of the letter you use must be sent to the Advice Centre when you submit your data at the end of the survey.

Covering letter for second reminder

To be printed on trust headed notepaper (ideally without trust telephone number if Approved Contractor is handling the FREEPHONE calls). Text in square brackets needs to be edited.

[Date]

Inpatient survey

Dear Patient,

Enclosed is a copy of a questionnaire about the care you received at [Hospital A] or [Hospital B] of the [NHS Trust name]. We originally sent the questionnaire to you a few weeks ago. **Your views are very important in helping us to find out how good the hospitals are and how they can be improved**, **so we would like to hear from you.** If you have already replied, please ignore this letter and accept our apologies.

We are asking you to give us your views by filling in the enclosed short questionnaire. The questionnaire should only take about 15 to 20 minutes to complete. A FREEPOST envelope is enclosed. This survey is part of our commitment, outlined in the NHS Plan, to design a health service around the patient. The survey is being carried out by researchers from [NHS Trust name /name of survey company], the Commission for Health Improvement and the NHS Surveys Advice Centre at Picker Institute Europe. This is your chance to have a say in how hospital services are provided in the future.

Your participation in the survey is entirely voluntary. If you choose not to take part it will not affect the care you receive from the NHS in any way. If you do not wish to take part in the survey, or you do not want to answer some of the questions, you do not need to give us a reason. If you do not return the questionnaire, you need do nothing more, and you will receive no further reminders.

If you do decide to give us your views, you can rest assured that your answers will be kept confidential. Information will not be passed on to doctors, nurses or other NHS health care staff in a form that allows you to be identified.

If you have any questions or need help with filling out the questionnaire, you can call [our FREEPHONE help line/ us] on [**phone number**] [at no cost to yourself]. The line is open between [opening time] and [closing time], [days] and we will try our best to answer any questions you may have.

Yours faithfully

[signature]

[print name of signatory]

Chief Executive [or similar]

[NHS Trust name]

13 Entering data

If an Approved Survey Contractor is used, they will be responsible for all of the data entry and checking, and when the survey is completed they should submit the data to the Advice Centre in the correct format and supply the trust with an anonymised data set.

13.1 Entering and coding data from the Core Questionnaire

The data should be entered into a pre-designed Excel file on the NHSSurveys website. There is a link to this file from the NHSSurveys website:

http://www.nhssurveys.org/

You will see that, at the bottom of the Excel screen, there are labelled tabs for each of the worksheets within the workbook. The first of these tabs is labelled "Data". Click on this tab to show the data entry window. Data should be entered using the following guidelines:

- Each row records one patient's responses to the survey.
- For each question, the small number next to the box ticked by the patient should be entered as the response
- If a response is missing for any reason, it should be left blank, or coded as a dash (-). [9]
- If two boxes are ticked (where only one should be ticked), the response should be left blank or coded as a dash (-).
- When saving this file to submit data to the Advice Centre, please save only the first sheet as a **worksheet**, rather than saving the whole file as a workbook. (This saves disk space.)

13.2 Entering data from Enhanced or Customised questionnaires

If you are using an Enhanced questionnaire, with questions added from the question bank, you will need to set up your own Excel file for entering all the data. Your data file will have columns corresponding to each of the questions in your questionnaire.

[9] If you want to use this data input file on the website to display frequencies on the other pages of the workbook, you will need to fill in the blank cells with a dash (-).

13.3 Adapting data file for sending data to Advice Centre

You will need to send the data for **only** the 50 compulsory core questions to the Advice Centre. In order to do this, you will need to include those columns of data that cover the responses to those 50 questions to the pre-designed Excel file available on the website. The columns of this standard Excel file are headed with the numbers corresponding to the question numbers in the Core Questionnaire. They also include the wordings of the 50 core questions so that you can match up questions from Enhanced Surveys with the core questions. Further details on supplying data to the Survey Advice Centre are given in Section 13.5.

13.4 Checking the data for errors

When the data have been entered, they need to be checked carefully for errors. That is:

1. Have the data been entered accurately? You can check this by double-entering the survey responses, and comparing the lines of data for any discrepancies. (For example, by subtracting each cell in one data sheet in Excel from a comparison sheet and comparing the results. If there are no differences between the two sheets, each cell will be zero.)

2. Are all the data entries valid responses for that question? For example, if a question allows three response options: "1", "2" or "3", check that your data do not include any other numbers.

3. Scanned data are also likely to contain errors and must be checked.

13.5 Submitting data to the Patient Survey Advice Centre

The NHS Trust Inpatient Survey data must be supplied to the NHS Patient Survey Advice Centre for the calculation of performance indicators. You are asked to submit one anonymised Excel file that includes information about the patient sample and responses.

File format

- Microsoft Excel Worksheet (not Workbook). Any version of the software is acceptable.
- File name must be in the format <NHSTrustName>_Inpatient2004.xls.
- One row of data for each patient in the sample.
- One column of data for each item of patient information or response.
- Missing data should be left blank or coded as a dash (-). [10]

Table 2 shows the information that must be provided for each of the 850 patients in the original sample.

[10] Data may be missing because the patient skipped a question or set of questions by following instructions. Alternatively, a patient may have not answered for some other reason. However, all missing data should be left blank or coded as a dash (-), regardless of the reason for the omission.

Table 2 - Data fields to be included in file submitted to Advice Centre

Field	Format	Data codes	Comments
Patient Record Number	N, NN, NNN or NNNN		The unique serial number allocated to each patient by the trust or Approved Survey Contractor administering the survey.
Year of birth	NNNN		Format this simply as a number, not in date format.
Gender	N	1 = male 2 = female	If gender is not known or unspecified, this field should be left blank or coded as a dash (-).
Ethnic Group	N	1 = White 2 = Mixed 3 = Asian or Asian British 4 = Black or Black British 5 = Chinese 6 = Other ethnic group	Ethnic Group should be included if the information is available.
Day of discharge	N or NN		For example, if the patient was discharged on Sept 16th 2003, this column should read 16.
Month of discharge	N or NN		For example, if the patient was discharged on Sept 16th 2003, this column should read 9.
Year of discharge	NNNN		For example, if the patient was discharged on Sept 16th 2003, this column should read 2003.
Outcome of sending questionnaire	N	1 = Returned useable questionnaire 2 = Returned undelivered by the mail service or patient moved house 3 = Patient died 4 = Patient reported too ill to complete questionnaire, opted out or returned blank questionnaire 5 = Patient was not eligible to fill in questionnaire 6 = Questionnaire not returned (reason not known)	Remember to fill in all the blank cells with 6s when the survey is complete.
Responses to each of the 50 core questions	N or NN or NNNN		Each column must be clearly headed with the **Core Questionnaire** question number. Data should be coded using the numbers next to the response boxes on the printed surveys. There is no need to send the comments to the Advice Centre.

Table 3 is an example of the columns of data to be included in the file. Your file should have 850 rows (one for each patient included in your sample). You will notice that there are several blank cells in the response section of the file. This is because the file includes a row for every patient in the sample, but you will only have responses from about 60% of the patients (that is, those who have returned a completed questionnaire, and who will therefore have an outcome code "1").

Table 3 – Example of data file to be submitted to Advice Centre

Patient Sample Information								*Patient Response Information*								
Patient Record Number	*Year of birth*	*Gender*	*Ethnic Group*	*Day of discharge*	*Month of discharge*	*Year of discharge*	*Outcome*	*Q1*	*Q2*	*Q3*	--	*Q46*	*Q47*	*Q48*	*Q49*	*Q50*
1001	1934	2	1	2	9	2003	3									
1002	1970	1	3	3	9	2003	1	1	1	5		1	1970	2	3	8
1003	1965	2	1	3	9	2003	6									
1004	1935	2	1	3	9	2003	1	2				2	1935	1	5	1
1005	1929	2	1	3	9	2003	1	1	3	1		2	1929	1	3	1
1006	1923	1	4	14	9	2003	2									
1849	1950	2	5	21	9	2003	6									
1850	1946	2	1	30	9	2003	1	1				2	1929	1	4	1

You do not need to send any of the patients' written comments to the Advice Centre.

Additional information

The following information should also be included when submitting the data file:

- **Contact details** (telephone numbers and e-mail addresses) of at least two personnel who will be available to answer any queries about the data.
- Two blank **paper copies** of the questionnaires you used, the covering letters and the reminder letters.
- A copy of the **checklist** on the next page.

Delivery

Trust survey data (on floppy disc) and additional information should be sent by post to the following address:

Inpatient Survey
Advice Centre for NHS Patient Survey Programme
Picker Institute Europe
King's Mead House
Oxpens Road
Oxford
OX1 1RX

Data files may also be e-mailed to: inpatient.data@pickereurope.ac.uk

Date

The data must be supplied by **31st March 2004**.

13.6 Checklist

Before sending your data to the Survey Advice Centre, carry out the checks listed below, and include this checklist when you submit paper copies of the questionnaire and covering letters.

Check	Done?
1. Check that your **file name** follows the naming convention: <NHSTrustName>_Inpatient2004.xls)	
2. Check that you have saved the data sheet only as an Excel **worksheet**, rather than a workbook. (The frequency and percentage counts on the other pages of the workbook are intended for your use only.)	
3. Check that all **data are correct**, and that all values are in range.	
4. Send data only for the **850 patients** consecutively discharged from your trust in the chosen month.	
4. To comply with Data Protection regulations, any **patient name and address details** must be removed before the file is sent to the Survey Advice Centre.	
5. Remove any **passwords**.	
6. Include **two paper copies** of the questionnaire you used.	
7. Include **two paper copies** of the covering letters you used for the first mailing, the second mailing and the third mailing.	
8. Include **contact details of 2 people** who will be available to respond to any queries about the data.	
9. Check that you have included data columns for **all 50 core questions.**	
10. Check that you have **not** included any columns of optional questions.	
11. Check that all the data are in **numeric format** only.	
12. **Check again** that all data are correct, and that all values are in range! ***See note below***.	

Very important

It is essential that these checks are carried out thoroughly. The Advice Centre is not obliged to make any corrections to data supplied by trusts or approved contractors.

If incorrect data are submitted, it is likely that the data will be considered unreliable and will not be used by CHI in your trust's performance ratings. We cannot accept re-submissions of data after the deadline.

14 Making sense of the data

The usefulness of your survey data will depend on how well you plan the survey process and on how effectively you analyse the data. Standard data analysis usually involves an analysis of the frequency of responses to each question and some cross-tabulation of responses against demographic and other information.

14.1 Using the NHSSurveys website to look at results

Once you have entered the data from the core questions into the Excel file on the website, the numbers and percentages of responses to each of the 50 core questions are automatically computed and displayed on the other sheets of that Excel workbook, which correspond to sections of the core inpatient questionnaire. For each question, the numbers and percentages of respondents who gave each answer is shown. The number of missing responses will also be shown, as long as you have coded missing responses on the data sheet as a dash (-).

14.2 Suggestions on data analysis

The following suggestions should help make the data analysis more useful and focused.

Use the data to help pinpoint problems

It is often tempting to focus on organisational strengths. This may be important for public relations and employee morale. However, if you emphasise only the positive, you may miss a critical opportunity to use the data to spur improvement.

One way to focus attention where improvements are needed is to analyse responses in terms of "problem scores" - that is, the proportion of answers that suggest a problem with care. Try to maintain high standards in determining what constitutes a problem. For example, if questions allow respondents moderate response categories (such as "to some extent" or "sometimes"), in addition to more extreme ones ("always" or "never"), your analysis will be more powerful if you identify these moderate responses, too, as indicating a problem.

"Drill down" into the data

It is impossible to analyse absolutely every issue a patient survey raises. One reasonable way to control the number of analytical questions is to conduct a staged analysis.

The **first** level of a staged analysis should be the most general - for example, summary measures or measures of overall performance. The next level should delve into particular issues that underlie the summary measures - performance along particular dimensions of care, for example, or of particular units or staff. The final level should entail statistical or cross-tab analysis to get at the causes of the particular issues.

Group similar questions together to provide summary analysis

Analysing and presenting an analysis of many questions in a way that is comprehensive, logical and not overwhelming is a significant challenge. To make the data more compelling, and to speed up the analysis:

- Link questions that cover similar topics or processes
- Combine several questions into a single composite measure (by averaging problem rates, for example)

Use statistical tests to make comparisons and subgroup analyses

Statistical tests can be used to examine relationships and associations between groups. These tests take into account the number of responses, the variation in responses, and values of the items you are comparing (such as average problem rate). If tests show that the differences between two groups are not statistically significant, you should view the patterns of responses as only suggestive.

Calculate confidence intervals to give an indication of the uncertainty surrounding your results

Although there are many methods of describing uncertainty, confidence intervals are used most often. By taking into account the number of responses, the variation in response, and the magnitude and direction of the estimate, the confidence interval describes the range of plausible values within which the "true" value for the population is likely to fall. Remember that the estimate itself is the most likely result, and this is therefore your best estimate, not the limits of the confidence interval.

Use patient feedback data with other data

Patient feedback data provide one valuable source of information about how patients experience and feel about the health services they receive. Linking feedback data with clinical data, outcomes data, and routinely collected data, when done appropriately, can provide useful insights.

15 Reporting results

15.1 Prioritising your report

Patient surveys can raise many compelling and important issues. How do you decide what issues to focus on first? The following suggestions can help with these decisions.

Compare your results against outside norms or benchmarks

A common method of prioritising is to select issues that compare unfavourably with national, regional, or local norms or with benchmark institutions. This allows you to focus on areas of comparative weakness. Compare your trust's results with the benchmarks on the CHI and NHSsurveys website to find out where your trust performs better or worse than other trusts.

Compare results over time

Investigating trends in survey results over time is a powerful analytical tool for prioritising. Analysis of trends allows you to focus on correcting aspects of performance that are slipping. For informative analysis of trends, however, sample sizes for each survey period must be large enough to achieve stable estimates of performance.

Rank problems by their magnitude

The most straightforward method of prioritising is to rank issues in order of the size of the problem and to focus first on those that are the greatest. For example, if 40% of the patients in a survey report a problem with privacy when discussing their condition or treatment, and if this problem rate is the largest, then quality improvement efforts might focus first on this issue.

Compare with predefined goals

One way to rationalise priorities is to set threshold or target goals prior to the survey. You would then focus on issues where performance does not meet these goals. This method is particularly effective when there is clear consensus on what those goals should be.

Correlation with overall measures

In some organisations, it is clear which overall or summary measures are most important. For example, a single overall rating on the quality of care may be of particular interest. Correlating patient responses to specific questions with this single most important indicator can help focus attention in a way that improves the overall measure. (It is important to remember that the distribution of survey responses is unlikely to be *normal* in the statistical sense, and so rank-based correlation methods are more appropriate e.g. Spearman's rank correlation coefficient.)

Predictive value on overall measures (regression analysis)

Similar to correlation, regression analysis also gives a sense of the issues that most sharply affect patients' overall assessments of care. Regression analysis is superior to simple correlation, in that it can adjust for other things that have an impact on the overall measure, and it provides more precise estimates of how overall measures will change in response to improvement on individual items. However, regression analysis is also much more complex and time consuming, but in essence, it allows for a more level 'playing field'. There is only so far you can take a univariate (crude) analysis and so regression analysis is an attractive option.

Ease of action

Many organisations focus initially on the issues that most easily present solutions. By demonstrating successful interventions, this prioritisation method can rally support for more difficult improvement efforts later on.

Areas of excellence

An organisation may also want to maintain excellence in areas where it is already perceived to be doing well. This approach can provide a clear and positive focus for clinical and administrative staff.

15.2 Writing the report

User-friendly reports that enable readers to understand and begin to take action on key issues are critical to the success of any survey project. The following suggestions will help you produce useful reports.

Gear the format to the audience

- Use brief, succinct summaries for executive audiences.
- Use comprehensive summaries for those who will implement improvements. They will help achieve buy-in and generate action.

- A resource booklet or data diskettes with full details may be important when problems arise, or if researchers have questions.

Use graphics

- Data that are displayed visually are easier to interpret.
- Display trends or comparisons in bar charts, pie charts, and line charts.
- Remember that colours don't photocopy or fax very well.

Keep the format succinct and consistent

- Graphics, bullets, tables, and other visuals help guide the reader.
- Choose a few of these elements and use them consistently.
- Too many types of graphic elements detract from the message.
- Be consistent in the use and appearance of headers, fonts, graphic styles, and placement of information.

Emphasise priorities clearly

- Emphasise the highest priority items for action or commendation in executive summaries and major findings.
- Highlight the most important items - for example, use bold type.

16 Using results for quality improvement

Applying the lessons and implementing change is the most useful aspect of the survey process. It is essential that this feedback is used to set priorities for quality improvement programmes and to create a more responsive, patient-centred service. It should then be possible to measure progress when the survey is repeated.

16.1 Prepare carefully

The most important way to ensure that the survey will result in improvement is to plan for improvement before the survey is conducted.

- The multi-disciplinary steering group should be responsible for developing a dissemination strategy to engage all of the relevant stakeholders and the co-ordination of improvement work.
- Publicise the survey before it happens. Engaging staff from the start will help to ensure their support with improvement initiatives. Involving the local media and informing the public will encourage a good response rate from patients.

16.2 Dissemination of survey results

Engage key stakeholders

Raising awareness of the survey programme in your organisation is vital. Publication is an excellent way to inspire staff to take patient feedback seriously. By communicating your survey results to key stakeholders you will help to ensure they are used effectively and not forgotten.

- Staff throughout the trust should be engaged in the dissemination process as they will be responsible for tackling any problems identified by patients.
- It is vital that board members are informed about the outcomes of the survey and that they are involved in prioritising areas for improvement and shaping action plans. Their support is crucial for the successful implementation of change.
- Patients have taken time to report their experiences so they have a right to be informed of the results via local meetings, newsletters and articles in the local press.
- Survey results should also be made available to members of Patients' Forums. They have a key role to play in initiating discussions with the board about priorities for improvement and they will be keen to monitor progress as it occurs.

- Key findings should also be reported in Your Guide to Local Health Services (Patient's Prospectus). When reporting these results it is a good idea to invite people to contribute their ideas on how services could be improved and to suggest ways in which they can become involved if they wish to.

Spread the Word

Disseminating survey results entails far more than producing and photocopying a report. Consider how to share results in training sessions, meetings, employee newsletters, executive communications, process improvement teams, patient care conferences, and other communications channels.

- Determine whether information should be shared initially with only senior-level people, or whether (and when) it should be spread wide and far.
- Make presentations to your trust board and to as many groups of staff as possible. Ensure that these meetings are tailored appropriately for each audience.
- Organise a high profile event to publicise the results and invite staff and patients to contribute to improvement plans.
- Encourage staff at all levels in the organisation to contribute their ideas for improving patients' experience.
- Publish the survey results on your website, including any intranet site and give readers the opportunity to feed back their ideas.
- Email staff to tell them about the survey results and the action plan.
- Share information with other NHS organisations in your area and other partner organisations including local authorities.
- Give the results to community organisations and ask them for their views and suggestions.
- Publicise results via local press, radio and community newsletters.
- Include information on survey results in Your Guide to Local Health Services.
- Publish results in your Trust newsletter along with details of improvement plans.

Promote understanding

- Make sure the results are presented in user-friendly formats. Remember not everyone will be an expert in reading graphs and deciphering data
- Pictures speak louder than words. Communicate information in a visual way, perhaps in the form of posters which can be displayed around your organisation

- Focus on key messages arising from the results and emphasise both the positive and negative themes.
- Illustrate themes with relevant patient comments or other forms of patient feedback to put the results in context.

16.3 Identify key "change agents"

- The people who can motivate others to change and who hold the keys to improvement in the organisation are not necessarily the most senior people.
- Identify those who hold the keys in your organisation, and involve these "change agents" early in the survey process.

16.4 Prioritising areas for improvement

Compare with other trusts

Compare your trust's results with the benchmarks on the CHI and NHSSurveys website to find out where your trust performs better or worse than other trusts.

Compare departments within your trust

If your data allow it, further analysis of your results by sites, wards or departments will provide a more detailed breakdown of performance. You may be able to identify examples of good practice within your trust which can be applied to other areas requiring improvement.

Identify where patients report most room for improvement

Issues can be ranked according to the size of the problem. Look at questions where more patients indicate that their care was not perfect and could be improved. Select the questions where most problems are reported and focus on the issues that are a priority for your organisation.

Focus on areas where work is already underway and solutions can be easily identified

Focusing on issues that present solutions (e.g. improving information provided to patients about medications they are given when they leave hospital) and choosing topics currently being considered by existing groups in your Trust (e.g. the Clinical Governance Group) will help to gain the ownership and involvement of staff and patients and avoid duplication of effort.

Identify problems surrounding particular aspects of the patient journey

There may be particular aspects of care or elements of the patient journey where more problems are reported than others. For example:

- The admission process
- Being seen and treated by one type of health professional
- Receiving information on tests
- Discharge arrangements

16.5 Develop an action plan

After using your survey results to identify areas for improvement, work with staff and patients to prioritise these and then identify the actions required. Decide on achievable timescales and on the individuals who will be responsible for taking this work forward. This will form the basis of an action plan which can be updated on a regular basis.

Wherever possible, link the information from the patient survey results with other activities in the trust. Use other sources of patient feedback from:

- Patient Advice and Liaison Service (PALS)
- Complaints
- Service Improvement / Modernisation Teams

Initially it is a good idea to focus on one or two key areas for improvement and not to attempt to tackle all of the issues at once. Publishing regular progress reports widely throughout your trust and the local area will help to enlist ongoing support. Repeat surveys can then be used to monitor any improvements.

16.6 Use small follow-up surveys or focus groups to delve deeper

Your initial survey can help you identify areas in need of improvement, but you might need more detailed information to design your improvement effort. It can be time-consuming and expensive to gather this information on a large scale. Small follow-up surveys to selected groups of patients can provide valuable information and faster feedback.

17 Appendix – Designing and testing new questions

This section gives guidance on designing your own questions and putting them into a survey. As noted in Section 10, the skill and effort required to design survey questions and put them together into a workable format is very often underestimated. For this reason, we **strongly recommend** that, unless you have considerable experience in questionnaire design, you should use only the standard pre-tested questions available on the NHSSurveys website.

However, we also recognise that there may be issues that are uniquely important for your trust that are not covered by the standard sets of questions. In such cases, it may be necessary to design your own questions.

17.1 Designing good questions

For a survey to produce accurate and useful results, the questions must be rooted in what patients say is important to them. Focus groups and patient complaint lines are a rich source of potential topics for survey questions. It is also important to pre-test questions with patients to get a sense of how relevant and understandable the questions are to them.

- **Topics should be specific enough to be relevant, but not so specific that the questions become tedious to answer**

  The more specific the topic of a particular question, the easier it will be for those who use the data to act on the results. However, if questions cover processes in too much detail, respondents may lose interest before they complete the survey.

- **Avoid topics that are politically sensitive or might embarrass patients**

  Sensitive topics can spur complaints about the survey and may lower response rates. These issues are better addressed in focus groups or face-to-face interviews.

- **Phrase questions in simple and straightforward language**

  Long words, complex sentence structures and technical terms can confuse respondents and make interpretation of their responses very difficult.

- **Use single subject questions whenever possible**

  Asking questions about two things at the same time ("double barrelled" questions) can lead to confusion and problems with interpretation. For example, a question that asked, "Did a nurse give you advice about caring for yourself at home or obtaining follow-up medical care?" would be difficult to answer. Respondents could be confused about how they should answer if their experiences of the advice given to them about those two issues differed. It would therefore be difficult to interpret responses to this question and it would not lend itself to an analysis that focused on either issue.

- **Avoid leading or biased questions**

  Questions that focus too strongly on a positive or negative experience can lead a respondent towards a particular response. For example, a question such as, "Were you unhappy with the amount of time it took to get through the admission process?" might lead respondents toward negative responses, thereby overstating the problem.

- **Limit the number of "open-ended" questions**

  Questions that call for a narrative response are often tempting, because they offer more detailed insights into respondents' experiences. However, such "open-ended" questions are difficult and expensive to input and analyse. They also add length to written surveys and can take respondents a long time to complete.

- **Consider the purpose of the question when selecting the wording and format**

  Survey questions generally fall into two categories: those that ask patients to report about their experience and those that ask them to rate their experiences.

  For example,

  "Did __ happen?" and "How much of __ did you get?" are report questions.

  "How would you rate __?" and "Please rate __ as poor, fair, good, very good, or excellent," are rating questions.

  Rating questions are used to elicit opinions or summary judgments about care. Reporting questions are more factual assessments of specific processes of care and can be used more effectively to suggest a clear course of action.

17.2 Layout of the questionnaire

- **Survey questions should lead a patient through their experiences in as natural a way as possible**

  Questions about similar issues should be grouped together. This allows for easier and more accurate recall. Also, where possible, it is preferable to put the questions in a sensible chronological order. For example, questions about admission should be put near the beginning of the questionnaire, while questions about discharge and follow-up should go towards the end.

- **Ensure that appropriate filters are included**

  A filter is an introductory question, which asks the patient whether a topic area is relevant to them. For example, a section on pain and pain relief should begin with the filter "Were you ever in any pain?" Those who answer "no" to this question are guided to skip the pain section and go straight to the next section. However, complex filters can sometimes confuse respondents.

Table 4 is a comparison of three different types of question: rating questions, report questions and open-ended questions.

Table 4 - Comparison of types of questions

Ratings	Reports	Open-ended
• Provide evaluations	• Find out about events; what happened	• Provide qualitative information
• Maximise variation by offering many response alternatives	• Objective, usually involve fewer response options than rating questions	• Unlimited topics
• May be influenced by feelings of gratitude	• Can be more specific than ratings	• Good source for anecdotes
• Evaluations tend to be positive	• More actionable than ratings	• More difficult to analyse and summarise than closed questions
• Good for summary measures (e.g., overall quality and overall satisfaction)	• Often easier to interpret than ratings	• Useful source of quotations for reports
• Dependent on expectations		

17.3 Examples of survey questions

Report question

Q. Did a member of staff tell you about medication side effects to watch for when you went home?

- ☐ Yes, completely
- ☐ Yes, to some extent
- ☐ No
- ☐ I didn't need an explanation

Rating question

Q. How would you rate the courtesy of the **catering staff**?

- ☐ Poor
- ☐ Fair
- ☐ Good
- ☐ Very Good
- ☐ Excellent

Open-ended question

What can we do to improve our services?

_____
_____
_____
_____
_____
_____

17.4 Pre-testing survey questions

Before launching a full-scale survey with a new instrument or new questions, surveys should be discussed and tested with a smaller group of patients. All questions should be pre-tested in face-to-face *cognitive* interviews. The pre-test should be done with a small but *carefully chosen* sample of respondents —that is, a sample chosen to represent all types of patients who will be surveyed.

Why bother with pre-testing?

Pre-testing is essential in order to:

- **Identify questions that are unclear, liable to misinterpretation, or difficult to answer**

  All items in a survey must lend themselves to uniform interpretation if the information they generate is to be reliable and valid. Ambiguity is not acceptable. If respondents misunderstand or cannot answer questions, the data collection is fruitless. Pre-testing each question allows you to avoid wasting valuable resources collecting information that cannot be interpreted.

- **Discover parts of the questionnaire that place an unacceptable burden on the respondent**

  By mixing types of questions (but not topics), you can avoid wearing respondents out. Asking too many questions about times and dates or other specific knowledge can cause a respondent to become frustrated and terminate an interview or toss aside a questionnaire before completing it.

- **Discover parts of the questionnaire that do not work, or that work with one population but not with another**

Selecting patients for the pre-test

- The survey should be pre-tested among all types or subsets of respondents who will be included in the final survey.
- If the questionnaire is to be used in a population of varying age, ethnicity, income, and levels of literacy, for example, then the pre-test should be done with a similarly diverse group of respondents.
- The pre-test may include a small number of respondents. Diversity is more important than quantity in your pre-test.

Suggestions for conducting a pre-test

- Conduct the pre-test in an environment that allows face-to-face, one-to-one contact with each respondent. Try to sit with respondents in a quiet place. Give them a paper-and-pencil version of the questionnaire you want to test and let them complete it on their own. Encourage them to ask questions about anything they do not understand. Take notes, and document the time it takes each person to complete the questionnaire. When they have completed the survey, ask specifically about the following:

- **Words.** Focus on meaning. Do they understand difficult words? Ask them to explain what they think some of the more difficult words mean.

- **Questions.** Focus on understanding. When they answered a question, what did they think it meant?

- **False positives.** Respondents may not say what they mean. (For example, they may say their admission was an emergency when in fact it was planned.) Probe for these classification misunderstandings - especially in questions that ask whether or not something happened.

- **False negatives.** Respondents may say something did not happen when in fact it did. Probe for events or conditions that may be misinterpreted. If a question asks about tests done in the hospital, for example, ask the patient what they thought "tests" meant.

- Try to make each respondent feel comfortable criticising the questions. For example:

    - *We know there are words and sentences and questions in here that aren't right, and other people have complained that some are hard to understand. Can you help us?*

    - *Were there any words or questions that were confusing, things that were hard to answer?*

    - *Did response scales put you off?*

    - *Were there questions that seemed irrelevant or silly or not important?*

    - *Were there important things we didn't ask about?*

One way to discover differences in meaning is to ask respondents to tell you, in their own words, what they think a question means. For example, consider the following question: "During your stay in hospital, did you have an operation or procedure?" You need to know if the respondent understands what "operation or procedure" means. Ask them to tell you what they think this question means.

- Pay close attention to body language and facial expressions, as well as to responses to direct questions. Some respondents may not feel comfortable answering questions about certain behaviours. If they feel uncomfortable answering a question, let them express their discomfort. Explain that you are not interested in their answer, but rather, in the source of their discomfort. Explain that you may eliminate questions if they are found to be inappropriate or poorly worded.

Inspecting Informing Improving

Patient survey report 2004

- adult inpatients

The survey of adult inpatient service users was designed, developed and coordinated by the NHS survey advice centre at Picker Institute Europe.

The Healthcare Commission exists to promote improvement in the quality of NHS and independent healthcare across England and Wales. It is a new organisation, which started work on April 1st 2004. The Healthcare Commission's full name is the Commission for Healthcare Audit and Inspection.

The Healthcare Commission was created under the Health and Social Care (Community Health and Standards) Act 2003. The organisation has a range of new functions and takes over some responsibilities from other commissions. It:

- replaces the work of the Commission for Health Improvement (CHI), which closed on March 31st 2004

- takes over the private and voluntary healthcare functions of the National Care Standards Commission, which also ceased to exist on March 31st 2004

- picks up the elements of the Audit Commission's work which relate to efficiency, effectiveness and economy of healthcare

In taking over the functions of CHI, the Healthcare Commission now has responsibility for the programme of national patient surveys initiated by CHI. This report relates to a patient survey that was begun by CHI but is published by the Healthcare Commission. The Healthcare Commission has full responsibility for this report.

Introduction

An important step in improving hospitals and other health services to ensure they are meeting the needs of the patient is to ask the patients themselves about their experiences and opinions. One way of doing this is to carry out surveys of patients who have recently used the health service. The Healthcare Commission is responsible for carrying out national surveys of the NHS. By running these surveys across the country and publishing the results, the Healthcare Commission is able to provide important feedback about the experience patients have of their local health service.

The Healthcare Commission has carried out five national surveys asking patients across England about their experiences of mental health, inpatient, ambulance, hospital care for children and primary care services. The NHS surveys advice centre at Picker Institute Europe developed the questionnaires and methodology[1].

This is one of five reports published by the Healthcare Commission and Picker Institute Europe that summarise the key findings from the surveys and describe the experiences of patients of each of these services. The first inpatient survey was conducted in 2002[2] and has been conducted again in 2004. This report summarises the key findings of the 2004 inpatient survey and highlights how the findings differ from 2002.

The Healthcare Commission will use the survey results as one way of assessing the performance of the NHS, and we expect individual trusts to use the results to identify how their services can be improved for patients.

Survey results for every NHS trust in England are available in detailed reports on http://www.healthcarecommission.org.uk

Who took part in the survey?

This survey was carried out in all acute and specialist NHS trusts in England that care for adult inpatients. Each of the 169 trusts identified a list of 850 eligible patients who had been discharged from the trust counting back from the last date of September, October or November 2003. Patients were eligible to take part if they had had at least one overnight stay, were over 18 years old and were not maternity or psychiatry patients. The sampled patients were sent a postal questionnaire and a covering letter, and up to two reminder letters were sent to non-responders.

Questionnaires were sent to 143,322 patients and 88,308 completed questionnaires were returned. This represents a 63% response rate, once undelivered questionnaires and deceased patients had been accounted for. Response rates varied between trusts from 46% to 81%. This compares to an overall response rate of 64% for the 2002 survey, with response rates varying between trusts from 47% to 83%.

The 2002 and 2004 surveys results were compared on all of the 24 questions that were directly comparable, for example those questions that were unchanged between the two surveys, or for which response options could be matched up in a way that made them comparable. The 2002 survey included patients aged 16 and over, but the 2004 survey included patients aged 18 and over, since patients aged 0-18 were covered in the young patient survey. These comparative analyses included only patients aged 18 and over. All differences that are noted in this report are statistically significant.

The questionnaire was largely composed of closed questions, but the final section invited respondents to comment on things that were particularly good about their hospital stay and things that could be improved. The quotes in boxes throughout this report are drawn from these comments and illustrate the survey findings.

The survey results show that, of respondents:

- 54% were women

- 12% were aged 16 to 35 years, 17% 36 to 50 years, 27% 51 to 65 years, 33% 66 to 80 years and 12% 81 or over

- 95% were white, 2% Asian or Asian British, 2% black or black British, less than 1% were mixed race, Chinese or from other ethnic groups

- 53% of patients rated their own health as good to excellent in the previous four weeks, and 46% very poor, poor or fair

It is important to compare the demographic characteristics of the responders and non-responders to the survey, as the responders may not be representative of all patients that use an NHS trust. Completed questionnaires were returned by similar proportions of men and women. Response rates were highest for 51-81 year olds, and lowest for 18-35 year olds.

Admission to hospital

Fifty-three per cent of all acute inpatients were admitted to hospital as an emergency after dialling 999, being referred by their GP or calling NHS Direct. Forty-seven per cent of patient admissions were planned in advance.

For those patients who were admitted through accident and emergency, 61% thought the care they received was very organised, 35% fairly organised, and 5% that the care was not at all organised. In 2002 57% of patients reported that care was very organised in accident and emergency.

For patients who were admitted to hospital through accident and emergency:

- 16% did not have to wait before admission to a room or ward and bed
- 41% waited less than two hours before admission to a room or ward and bed
- 18% waited two to four hours
- 19% waited four to eight hours
- 7% waited eight hours or longer

This shows a marked improvement in waiting times since the 2002 survey when 15% of patients waited more than eight hours for admission, and only 13% were admitted immediately.

> "Admission from accident and emergency to the wards could not be faulted"

> "The long delays in the emergency/accident department waiting for a bed were a cause for concern"

For patients whose admission to hospital was planned, almost a quarter were given a choice of admission date and 9% were given a choice of hospital. The admission date was changed at least once by the hospital in 21% of cases. In general 96% of patients felt they were given enough notice of the admission date. The majority of patients felt they were admitted as soon as they thought was necessary, but 30% thought they should have been admitted sooner.

The hospital and ward

Eleven per cent of patient felt that they definitely had to wait a long time to get to a bed on a ward, 19% felt they had to wait too long to some extent and 69% did not felt that they had to wait too long.

During their stay 22% shared a room with people from the opposite sex.

> "I don't think it is a good idea to mix men and women in the same ward; at times it became very embarrassing"

Over one third of patients (39%) were bothered by noise at night from other patients, while 19% were bothered by noise from hospital staff.

> "Some patients, through no fault of their own, were very noisy in the night and made sleep very difficult"

Just over half the respondents rated the ward as very clean, 38% rated it clean and 9% thought the ward was not clean. In 2004 fewer patients thought the toilets and bathrooms in hospital were very clean than in 2002, with 51% reporting them as very clean in 2002 and 48% in 2004. Twelve per cent of respondents in 2004 thought the toilets were not clean.

> "The general cleanliness of the ward could have been greatly improved"

Of those respondents who ate hospital food during their stay, more than half thought it was good or very good, and 15% said it was poor.

> "The food was top class, very varied and was presented nicely"

Doctors and nurses

It is important for patients to have confidence and trust in members of staff and to feel they are able to communicate with them.

Answers to questions

Two thirds of patients said that they always got an answer that they could understand from a doctor, and 29% sometimes got answers they could understand. Similarly 68% of patients reported they always received answers they could understand from nurses, and 28% sometimes received answers they could understand. This indicates an improvement compared to the 2002 survey results, which showed that 63% of patients felt they always got answers they could understand from a nurse.

> "The doctors were very good and explained my treatment clearly. They treated me as an individual and gained my trust"

Confidence and trust

Most patients (80%) said that they always had confidence and trust in the doctor treating them, 17% reported that they sometimes had confidence and trust, and 3% said they did not. Three quarters of patients always had confidence and trust in the nurse treating them, 22% sometimes and 3% not at all.

> "Staff were all caring and very professional in their approach and at the same time friendly"

> "The nursing staff were happy in their work which in turn encourages recovery"

Respect

Patients often commented that doctors and nurses talked in front of them as if they were not there. This was most commonly reported about doctors in this survey, with 28% of patients reporting that it occurred often or some of the time. One in five patients experienced this with nurses.

Patient care and treatment

Information and involvement in decisions

Patients should be involved in decisions about their care as much as possible and given information about their condition. Nearly half reported that they would have liked to be more involved in decisions about their care and treatment. The majority of patients felt they were given the right amount of information, although 20% thought they had been given too little, and 1% too much.

Forty-two per cent of patients who had worries or fears said that they found a member of staff they were able to discuss them with, 38% were able to discuss their worries and fears to some extent, and a fifth reported that they were unable to find anyone to discuss them with.

> "The surgeons were very caring, helpful and informative prior to and after my operation"

> "I would have liked more information about what they were going to do, what they did and how you would feel after an operation"

> "I was very frightened about having an operation but the surgeon put me at ease (I had never had an operation before). He made me feel a lot better about it and I didn't feel quite as nervous"

Patients were asked whether hospital staff had given them conflicting information. Most respondents (68%) said that this did not happen, although a quarter reported that it had sometimes happened, and 6% said it had happened often.

Involving family and friends

For those whose family members or close friends wanted to talk to a doctor almost half were definitely given the opportunity to do this, 39% to some extent and 16% no opportunity. This represents a 3% increase in the patients who reported that opportunities were definitely given, compared to the 42% result in 2002. The percentage of patients reporting that there was no opportunity for a family member or someone close to talk to a doctor fell by 3% from 19% in 2002.

Privacy

Almost all respondents were given enough privacy when being examined. Sixty-nine percent of patients were always given enough privacy when discussing their condition or treatment, 22% were sometimes given enough privacy and 9% were not.

> “My privacy was maintained throughout”

> “Some doctors talk very loudly although the curtains were closed around the bed for privacy. The doctor’s diagnosis and proposed care plans could be heard by most other patients and visitors on the ward”

Staffing levels

In order for patients to receive individual attention and care it is essential that an adequate number of nurses are available to care for them. Over half the patients reported that there were always or nearly always enough nurses on duty, but almost a third reported that there were enough nurses only some of the time and 11% that there were rarely or never enough nurses.

> “There were not enough nurses to give proper care and attention to patients needs”

The majority of patients received help within one to two minutes of pressing the call button, and a quarter were attended to within three to five minutes. However, 11% had to wait more than five minutes and 1% said that they did not receive help when they used the call button.

Pain

Of the two thirds of patients who suffered pain during their hospital stay, 73% felt that the hospital staff did everything they could to help control it. A fifth thought they were helped to some extent and 5% felt this was not the case.

> “I was in a lot of pain but it was always relieved promptly”

> “I was in a lot of pain following surgery which I wasn't expecting - this could have been handled better”

Tests

For patients who underwent tests, x-rays or scans, the majority were performed on time, almost a quarter were sometimes on time and 8% never had them performed on time. Compared to the 2002 survey results, 3% fewer patients thought that tests, x-rays or scans were always performed on time in 2004.

Leaving Hospital

Discharge delays

Delays in being discharged from hospital can be upsetting and frustrating for patients. Over one third of patients reported that their discharge from hospital was delayed on the day they left.

- 47% were delayed for up to two hours
- 32% delayed for between two and four hours
- 20% over four hours

The main reason reported for delay in discharge from hospital was waiting for medicines (62% of cases). Waiting to see a doctor for was the reason for delay for 16% of respondents and waiting for an ambulance the reason for delay for 9%.

> "When I was due for discharge the ambulance arrived but medicines were not ready. Then by the time the medicines were ready there were no ambulances"

Information on medicines

Patients discharged with medication were asked about the information they received about the purpose of the medication, and any side effects. Almost all patients received a complete explanation of the medication's purpose. Thirty-nine per cent of patients were given a full explanation of possible side effects, 18% were given some information, and 43% were not given information. The percentage of patients that completely understood the explanation by staff of the purposes of medication to be taken at home fell from 79% in 2002 to 77% in 2004.

The majority of patients were given at least some information on the danger signals to watch for following discharge from hospital, although just over a third were not given any such information. Doctors and nurses gave information to family or friends to help the patients' recovery in over two thirds of cases. Most patients knew who to contact if they were worried about their condition after leaving hospital, although 24% were not given this information.

Overall

Ninety-one per cent of patients rated the care that they received in hospital as good, very good or excellent. The percentage of patients receiving what they perceived to be excellent care overall increased to 42% in 2004, an improvement of 4% from 2002.

Almost all patients (93%) thought that the doctors and nurses worked well together.

Over two thirds (79%) of patients said that they were always treated with respect and dignity while they were in hospital, 18% were treated with respect and dignity sometimes and 3% said they were not treated with respect and dignity.

> "I was treated with dignity and compassion all through my stay"

Conclusions

This is the second survey of inpatient care in acute and specialist trusts in England, and describes the experiences of more than 88,000 adults who were admitted to hospital.

Over 90% of people rated their care as excellent, very good or good, and, notably, there were a number of areas where services have improved since the last survey in 2002:

- there has been a reduction in the number of emergency patients waiting a long time before admission to a room or ward and bed, with 26% waiting more than four hours, compared to 33% in 2002. Patients also reported that the organisation of care in emergency departments has improved
- more patients reported that they got answers they could understand from nurses, and more patients felt that there was an opportunity for their family to talk to a doctor, compared with two years ago

In some areas, patients reported more negative experiences than in 2002. Fewer had results of tests on time, fewer felt that the purpose of medication was were explained, and fewer thought that toilets and bathrooms were very clean.

Despite improvements, and the continuing high degree of confidence and trust that patients have in doctors and nurses, the detailed responses from patients identify three areas where basic standards of care could be improved:

- the hospital environment, with levels of cleanliness, noise, lack of privacy and mixed sex wards remain a problem for some patients
- information for patients and their involvement in and understanding of their care. This is fundamental to patients giving consent to treatment and exercising choice
- delays on the day of discharge home from hospital, and poor or lacking advice about medication side effects, problems to look out for, and when patients should resume activities of daily life

Appendix: Tables of results

National average results are presented for each question, along with tables comparing respondents and non-respondents, and comparisons of results with the 2002 survey, for relevant questions.

The results reported are results for the average NHS trust in England. The responses from each trust have an equal influence over the national average, regardless of differences in response rate between trusts.

The proportion of responses to each response option for each individual question was calculated for each trust. The overall national average for a given response was then calculated as an average of all the trusts' proportions.

The only exceptions to this approach were in the figures for the demographics (for example age, sex and ethnic group). These are given as simple percentages, as it is more appropriate to present the real percentages of sampled patients and respondents, rather than average figures.

Tables of results: Trust based national averages for all questions

Admission to hospital

Q1 Was your hospital stay planned in advance or an emergency?

	National average %	Number
Emergency/dialled 999/immediately referred by GP or NHS direct	53	
Waiting list or planned in advance	47	
Total specific responses		80593
Missing responses		4147
Something else		3568

Answered by all

Emergency or immediately referred

Q2 How organised was the care you received in A&E (or the medical admissions unit)?

	National average %	Number
Not at all organised	5	
Fairly organised	35	
Very organised	61	
Total specific responses		41912
Missing responses		1144

Answered by emergency patients

Q3 Following arrival at the hospital, how long did you wait before admission to a room or ward and bed?

	National average %	Number
Less than 1 hour	27	
At least 1 hour but less than 2 hours	14	
At least 2 hours but less than 4 hours	18	
At least 4 hours but less than 8 hours	19	
8 hours or longer	7	
I did not have to wait	16	
Total specific responses		40198
Missing responses		1261
Can't remember		1685

Answered by emergency patients

Waiting list or planned admission

Q4 How do you feel about the length of time you were on the waiting list before your admission to hospital?

	National average %	Number
I was admitted as soon as I thought necessary	70	
I should have been admitted a bit sooner	19	
I should have been admitted a lot sooner	11	
Total specific responses		38855
Missing responses		3700

Answered by patients who had been on a waiting list

Q5 When you were told you would be going into hospital were you given enough notice of the date of your admission?

	National average %	Number
Yes, enough notice	96	
No, not enough notice	4	
Total specific responses		39089
Missing responses		3481

Answered by patients who had been on a waiting list

Q6 Were you given a choice of admission date by the hospital?

	National average %	Number
Yes	24	
No	76	
Don't know/can't remember		1301
Total specific responses		37659
Missing responses		3585

Answered by patients who had been on a waiting list

Q7 Was your admission date changed by the hospital?

	National average %	Number
No	79	
Yes, once	17	
Yes, 2 or 3 times	4	
Yes, 4 times or more	0	
Total specific responses		38961
Missing responses		3563

Answered by patients who had been on a waiting list

Q8 Were you given a choice about which hospital you were admitted to?

	National average %	Number
Yes	9	
No	91	
Don't know/can't remember		457
Total specific responses		38793
Missing responses		3365

Answered by patients who had been on a waiting list

All types of admission

Q9 From the time you arrived at the hospital, did you feel that you had to wait a long time to get to a bed on a ward?

	National average %	Number
Yes, definitely	11	
Yes, to some extent	19	
No	69	
Total specific responses		85252
Missing responses		3056

Answered by all

The hospital and ward

Q10 During your stay in hospital, did you ever share a room or bay with patients of the opposite sex?

	National average %	Number
Yes	22	
No	78	
Total specific responses		86235
Missing responses		2073

Answered by all

Q11 Were you ever bothered by noise at night from other patients?

	National average %	Number
Yes	39	
No	61	
Total specific responses		86008
Missing responses		2300

Answered by all

Q12 Were you ever bothered by noise at night from hospital staff?

	National average %	Number
Yes	19	
No	81	
Total specific responses		85990
Missing responses		2318

Answered by all

Q13 In your opinion, how clean was the hospital room or ward that you were in?

	National average %	Number
Very clean	54	
Fairly clean	38	
Not very clean	7	
Not at all clean	2	
Total specific responses		86792
Missing responses		1516

Answered by all

Q14 How clean were the toilets and bathrooms that you used in hospital?

	National average %	Number
Very clean	48	
Fairly clean	39	
Not very clean	9	
Not at all clean	3	
Total specific responses		84970
Missing responses		1677
I did not use a toilet or bathroom		1661

Answered by all

Q15 How would you rate the hospital food?

	National average %	Number
Very good	18	
Good	36	
Fair	31	
Poor	15	
Total specific responses		83248
Missing responses		1732
I did not have any hospital food		3328

Answered by all

Doctors

Q16 When you had important questions to ask a doctor, did you get answers that you could understand?

	National average %	Number
Yes, always	65	
Yes, sometimes	29	
No	5	
Total specific responses		77787
Missing responses		1894
I had no need to ask		8627

Answered by all

Q17 Did you have confidence and trust in the doctors treating you?

	National average %	Number
Yes, always	80	
Yes, sometimes	17	
No	3	
Total specific responses		86724
Missing responses		1584

Answered by all

Q18 Did doctors talk in front of you as if you weren't there?

	National average %	Number
Yes, often	6	
Yes, sometimes	22	
No	72	
Total specific responses		86119
Missing responses		2189

Answered by all

Nurses

Q19 When you had important questions to ask a nurse, did you get answers that you could understand?

	National average %	Number
Yes, always	68	
Yes, sometimes	28	
No	4	
Total specific responses		77138
Missing responses		1637
I had no need to ask		9533

Answered by all

Q20 Did you have confidence and trust in the nurses treating you?

	National average %	Number
Yes, always	75	
Yes, sometimes	22	
No	3	
Total specific responses		86282
Missing responses		2026

Answered by all

Q21 Did nurses talk in front of you as if you weren't there?

	National average %	Number
Yes, often	4	
Yes, sometimes	16	
No	80	
Total specific responses		86514
Missing responses		1794

Answered by all

Q22 In your opinion, were there enough nurses on duty to care for you in hospital?

	National average %	Number
There were always or nearly always enough nurses	58	
There were sometimes enough nurses	31	
There were rarely or never enough nurses	11	
Total specific responses		86323
Missing responses		1985

Answered by all

Your care and treatment

Q23 Sometimes in a hospital, a member of staff will say one thing and another will say something quite different. Did this happen to you?

	National average %	Number
Yes, often	6	
Yes, sometimes	25	
No	68	
Total specific responses		86309
Missing responses		1999

Answered by all

Q24 Were you involved as much as you wanted to be in decisions about your care and treatment?

	National average %	Number
Yes, definitely	52	
Yes, to some extent	36	
No	11	
Total specific responses		85773
Missing responses		2535

Answered by all

Q25 How much information about you condition or treatment was given to you?

	National average %	Number
Not enough	20	
The right amount	79	
Too much	1	
Total specific responses		86371
Missing responses		1937

Answered by all

Q26 If your family or someone else close to you wanted to talk to a doctor, did they have enough opportunity to do so?

	National average %	Number
Yes, definitely	45	
Yes, to some extent	39	
No	16	
Total specific responses		58835
Missing responses		2838
No family or friends were involved		8613
My family did not want or need information		14527
I did not want my family or friends to talk to a doctor		3495

Answered by all

Q27 Did you find someone on the hospital staff to talk to about your worries and fears?

	National average %	Number
Yes, definitely	42	
Yes, to some extent	38	
No	20	
Total specific responses		53410
Missing responses		2473
I had no worries or fears		32425

Answered by all

Q28 Were you given enough privacy when discussing your condition or treatment?

	National average %	Number
Yes, always	69	
Yes, sometimes	22	
No	9	
Total specific responses		85087
Missing responses		3221

Answered by all

Q29 Were you given enough privacy when being examined or treated?

	National average %	Number
Yes, always	87	
Yes, sometimes	10	
No	2	
Total specific responses		86483
Missing responses		1825

Answered by all

Q30 How many minutes after you used the call button did it usually take before you got the help you needed?

	National average %	Number
0 minutes - right away	22	
1-2 minutes	41	
3-5 minutes	25	
More than 5 minutes	11	
I never got help when I used the call button	1	
Total specific responses		47046
Missing responses		2930
I never used the call button		38332

Answered by all

Q31 During your stay in hospital, did you have any tests, x-rays or scans other than blood or urine tests?

	National average %	Number
Yes	67	
No	33	
Total specific responses		85045
Missing responses		3263

Answered by all

Q32 Were your scheduled tests, x-rays or scans performed on time?

	National average %	Number
Yes, always	68	
Yes, sometimes	24	
No	8	
Total specific responses		55292
Missing responses		2640

Answered by those who had tests other than blood or urine tests

Pain

Q33 Were you ever in any pain?

	National average %	Number
Yes	67	
No	33	
Total specific responses		84892
Missing responses		3416

Answered by all

Q34 Did you think the hospital staff did everything they could to help control your pain?

	National average %	Number
Yes, definitely	73	
Yes, to some extent	22	
No	5	
Total specific responses		56715
Missing responses		1035

Answered by those who experienced pain

Leaving hospital

Q35 On the day you left hospital, was your discharge delayed for any reason?

	National average %	Number
Yes	38	
No	62	
Total specific responses		85052
Missing responses		3256

Answered by all

Q36 What was the main reason for the delay?

	National average %	Number
I had to wait for medicines	62	
I had to wait to see the doctor	16	
I had to wait for an ambulance	9	
Something else	13	
Total specific responses		30620
Missing responses		1618

Answered by those who were discharged later than intended due to a delay

Q37 How long was the delay?

	National average %	Number
Up to 1 hour	18	
Longer than 1 hour but no longer than 2 hours	29	
Longer than 2 hour but no longer than 4 hours	32	
Longer than 4 hours	20	
Total specific responses		31605
Missing responses		610

Answered by those who were discharged later than intended due to a delay

Q38 Did a member of staff explain the purpose of the medicines you were to take at home in a way you could understand?

	National average %	Number
Yes, completely	77	
Yes, to some extent	15	
No	7	
Total specific responses		64644
Missing responses		4090
I did not need an explanation		8957
I had no medicines		10617

Answered by all

Q39 Did a member of staff tell you about medication side effects to watch for when you went home?

	National average %	Number
Yes, completely	39	
Yes, to some extent	18	
No	43	
Total specific responses		51975
Missing responses		1444
I did not need an explanation		20641

Answered by those who had medicines to take at home

Q40 Did a member of staff tell you about any danger signals you should watch for after you went home?

	National average %	Number
Yes, completely	39	
Yes, to some extent	21	
No	40	
It was not necessary		22086
Total specific responses		60831
Missing responses		5391

Answered by all

Q41 Did the doctors or nurses give your family or someone close to you all the information they needed to help you recover?

	National average %	Number
Yes, definitely	43	
Yes, to some extent	24	
No	33	
Total specific responses		58788
Missing responses		4971
No family or friends were involved		10148
My family or friends did not want or need information		14401

Answered by all

Q42 Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?

	National average %	Number
Yes	76	
No	24	
Don't know/can't remember		6931
Total specific responses		76991
Missing responses		4386

Answered by all

Overall

Q43 Overall, did you feel you were treated with respect and dignity while you were in the hospital?

	National average %	Number
Yes, always	79	
Yes, sometimes	18	
No	3	
Total specific responses		86079
Missing responses		2229

Answered by all

Q44 How would you rate how well the doctors and nurses worked together?

	National average %	Number
Excellent	39	
Very good	39	
Good	15	
Fair	6	
Poor	2	
Total specific responses		85449
Missing responses		2859

Answered by all

Q45 Overall, how would you rate the care you received?

	National average %	Number
Excellent	42	
Very good	35	
Good	14	
Fair	6	
Poor	2	
Total specific responses		85487
Missing responses		2821

Answered by all

About you

Proportions of those responding to the survey by sex (Q46)

	Proportion of responders	Total
Male	46%	
Female	54%	
Total specific responses		86119
Missing response		2205

Answered by all

Proportions of those responding to the survey by age group

	Proportion	Total
18-35	12%	
36-50	17%	
51-65	26%	
66-80	33%	
>80	12%	
Total specific responses		83415
Missing responses		4909

Based on patients' responses to question 47

Proportions of those responding to the survey by ethnic group

	Proportion	Total
White	95%	
Asian or Asian British	2%	
Black or Black British	2%	
Mixed race, Chinese, or other ethnic group	.5%	
Total specific responses		85267
Missing responses		3057

Based on patients' responses to question 50

Proportions of those responding by self reported health in the last four weeks

	Proportion	Total
Excellent	7%	
Very good	19%	
Good	27%	
Fair	31%	
Poor	12%	
Very poor	3%	
Total specific responses		85101
Missing responses		3223

Based on patients' responses to question 49

Proportions of those responding by self rating of health in the last four weeks

	Proportion	Total
Excellent, very good, or good	53%	
Fair, poor, or very poor	46%	
Total specific responses		85101
Missing responses		3223

Based on patients' responses to question 49

Response rates for demographic groups

Adjusted response rates by sex

Proportion returning completed questionnaire

Sex	Adjusted response rate	Total specific responses
Male	63%	64296
Female	64%	75055
Total	63%	139351

Adjusted response rates by age group

Proportion returning completed questionnaire

Age group	Adjusted response rate	Total specific responses
18-35 years	44%	20268
36-50 years	57%	24936
51-65 years	72%	31592
66-80 years	74%	39815
81 years or over	57%	22282
Total	64%	138893

Adjusted response rate by age group and sex

Proportion returning completed questionnaire

Sex	Age group	Adjusted response rate	Total specific responses
Male	18-35 years	37%	8444
	36-50 years	52%	11042
	51-65 years	70%	15816
	66-80 years	74%	20373
	81 years or over	64%	8340
Female	18-35 years	49%	11814
	36-50 years	62%	13879
	51-65 years	74%	15745
	66-80 years	73%	19408
	81 years or over	54%	13923
Total		63%	138784

Adjusted response rates by ethnic group

Proportion returning completed questionnaire

Ethnic Group from sample information	Adjusted response rate	Total specific responses
White	65%	90679
Asian or Asian British	47%	3961
Black or Black British	50%	2454
Mixed race, Chinese, or other ethnic group	56%	4626
Total	64%	101720

Tables of differences between comparable items in the 2002 and 2004 inpatient surveys using trust based national averages

Note: All figures are rounded to whole numbers which may account for apparent inconsistencies between the columns showing results for each year, and the difference column

Q2. How organised was the care you received in A&E (or the medical admissions unit)?

	2002	2004	difference
Not at all organised	6%	5%	-1%
Fairly organised	37%	35%	-3%
Very organised	57%	61%	4%
Total specific responses	44522	41912	

Answered by emergency patients

Q3. Following arrival at the hospital, how long did you wait before admission to a room or ward and bed?

	Adult inpatient survey		
	2002	2004	change
Less than 4 hours a	67%	74%	7%
4 hours or longer b	34%	26%	-8%
Base (n)	43282	40198	

Answered by emergency patients (i.e. Q1 = 1)

a. Summation of all response options that indicate a wait of less than 4 hours, including "I did not have to wait".
b, Summation of all response options that indicate a wait of 4 hours or more

Q4. How do you feel about the length of time you were on the waiting list before your admission to hospital?

	2002	2004	difference
I was admitted as soon as I thought necessary	68%	70%	2%
I should have been admitted a bit sooner	20%	19%	-1%
I should have been admitted a lot sooner	12%	11%	-1%
Total specific responses	40928	38855	

Answered by patients who had been on a waiting list

Q5. When you were told you would be going into hospital, were you given enough notice of your date of admission?

	2002	2004	difference
Yes, enough notice	96%	96%	0%
No, not enough notice	4%	4%	0%
Total specific responses	41252	39089	

Answered by emergency patients

Q7. Was your admission date changed by the hospital?

	2002	2004	difference
No	78%	79%	1%
Yes, once	17%	17%	0%
Yes, 2 or 3 times	4%	4%	-1%
Yes, 4 times or more	1%	0%	0%
Total specific responses	41252	38961	

Answered by emergency patients

Q9. From the time that you arrived at the hospital, did you feel that you had to wait a long time to get to a bed on a ward? (a)

	2002	2004	difference
Yes, definitely	13%	11%	-2%
Yes, to some extent	20%	19%	-1%
No	67%	69%	3%
Total specific responses	89441	85252	

Answered by all

(a) In 2002 survey question reads "Did you feel that you had to wait a long time to get to your room or ward and bed?"

Q10. During your stay in hospital, did you ever share a room or bay with patients of the opposite sex? (a)

	2002	2004	difference
Yes	26%	22%	-4%
No	74%	78%	4%
Total specific responses	92240	86235	

Answered by all

(a) In 2002 survey question read "During your stay in hospital, did you ever share a room or ward with patients of the opposite sex?"

Q13. In your opinion, how clean was the hospital room or ward that you were in?

	2002	2004	difference
Very clean	56%	54%	-3%
Fairly clean	36%	38%	2%
Not very clean	6%	7%	1%
Not at all clean	2%	2%	0%
Total specific responses	92889	86792	

Answered by all

Q14. How clean were the toilets and bathrooms that you used in hospital?

	2002	2004	difference
Very clean	51%	48%	-3%
Fairly clean	37%	39%	2%
Not very clean	9%	9%	1%
Not at all clean	3%	3%	0%
Total specific responses	91002	84970	

Answered by all

Q15. How would you rate the hospital food?

	2002	2004	difference
Very good	18%	18%	0%
Good	35%	36%	1%
Fair	31%	31%	0%
Poor	16%	15%	-1%
Total specific responses	88629	83248	

Answered by all

Q16. When you had important questions to ask a doctor, did you get answers that you could understand?

	2002	2004	difference
Yes, always	65%	65%	0%
Yes, sometimes	29%	29%	0%
No	6%	5%	-1%
Total specific responses	81378	77787	

Answered by all

Q18. Did doctors talk in front of you as if you weren't there?

	2002	2004	difference
Yes, often	6%	6%	0%
Yes, sometimes	23%	22%	0%
No	71%	72%	1%
Total specific responses	92027	86119	

Answered by all

Q19. When you had important questions to ask a nurse, did you always get answers that you could understand?

	2002	2004	difference
Yes, always	63%	68%	4%
Yes, sometimes	31%	28%	-3%
No	6%	4%	-1%
Total specific responses	78463	77138	

Answered by all

Q21. Did nurses talk in front of you as if you weren't there?

	2002	2004	difference
Yes, often	4%	4%	0%
Yes, sometimes	15%	16%	1%
No	81%	80%	-1%
Total specific responses	92354	86514	

Answered by all

Q23. Sometimes in a hospital, a member of staff will say one thing and another will say something quite different. Did this happen to you?

	2002	2004	difference
Yes, often	6%	6%	0%
Yes, sometimes	24%	25%	1%
No	70%	68%	-1%
Total specific responses	92322	86309	

Answered by all

Q26. If your family or someone else close to you wanted to talk to a doctor, did they have enough opportunity to do so?

	2002	2004	difference
Yes, definitely	42%	45%	2%
Yes, to some extent	38%	39%	1%
No	19%	16%	-4%
Total specific responses	63869	58835	

Answered by all

Q28. Were you given enough privacy when discussing your condition or treatment?

	2002	2004	difference
Yes, always	69%	69%	1%
Yes, sometimes	21%	22%	1%
No	10%	9%	-2%
Total specific responses	90879	85087	

Answered by all

Q29. Were you given enough privacy when being examined or treated?

	2002	2004	difference
Yes, always	87%	87%	0%
Yes, sometimes	10%	10%	0%
No	3%	2%	0%
Total specific responses	92326	86483	

Answered by all

Q32. Were your scheduled tests, x-rays, or scans performed on time?

	2002	2004	difference
Yes, always	71%	68%	-3%
Yes, sometimes	21%	24%	3%
No	8%	8%	0%
Total specific responses	59072	55292	

Answered by patients who had tests, x-rays, or scans other than blood or urine tests during their stay in hospital

Q34. Do you think the hospital staff did everything they could do to help control your pain?

	2002	2004	difference
Yes, definitely	73%	73%	1%
Yes, to some extent	22%	22%	0%
No	5%	5%	-1%
Total specific responses	60515	56715	

Answered by patients who were in pain at some point during their stay in hospital

Q38. Did a member of staff explain the purpose of the medicines you were to take at home in a way you could understand?

	2002	2004	difference
Yes, completely	79%	77%	-2%
Yes, to some extent	14%	15%	1%
No	7%	7%	0%
Total specific responses	68883	64644	

Answered by all

Q39. Did a member of staff tell you about medication side effects to watch for when you went home?

	2002	2004	difference
Yes, completely	39%	39%	-1%
Yes, to some extent	16%	18%	2%
No	44%	43%	-1%
Total specific responses	54071	51975	

Answered by patients who were given medicines to take at home

Q40. Did a member of staff tell you about any danger signals you should watch for after you went home? (a)

	2002	2004	difference
Yes, completely	41%	39%	-2%
Yes, to some extent	20%	21%	1%
No	39%	40%	1%
Total specific responses	88936	60831(b)	

Answered by all

(a) In 2002 survey question read "Did someone tell you about what danger signals regarding your illness or treatment to watch for after you went home?"

(b) 2004 survey includes an extra response option not included in 2002 survey: "It was not necessary"

Q41. Did the doctors or nurses give your family or someone close to you all the information they need to help you recover?

	2002	2004	difference
Yes, definitely	43%	43%	-1%
Yes, to some extent	24%	24%	0%
No	33%	33%	0%
Total specific responses	63190	58788	

Answered by all

Q43. Overall, did you feel that you were treated with respect and dignity while you were in the hospital?

	2002	2004	difference
Yes, always	79%	79%	1%
Yes, sometimes	18%	18%	0%
No	3%	3%	0%
Total specific responses	92222	86079	

Answered by all

Q45. Overall, how would you rate the care you received?

	2002	2004	difference
Excellent	38%	42%	4%
Very good	36%	35%	-1%
Good	17%	14%	-3%
Fair	7%	6%	-1%
Poor	2%	2%	0%
Total specific responses	92170	85487	

Answered by all

References

1. Reeves, R., Coulter, A., Jenkinson, C., Cartwright, J., Bruster, S., and Richards, N. Development and pilot testing of questionnaire for use in the acute NHS Trust inpatient survey programme. 2002. Oxford, Picker Institute Europe

2. Department of Health, Acute inpatient survey, national overview 2001/2, 2003. http://www.dh.gov.uk/assetRoot/04/06/65/98/04066598.pdf

Acknowledgements

The Healthcare Commission would like to thank the patients, service users and parents who responded to the surveys, as well as the NHS trusts in England that participated. This report was written by Rachel Reeves, Judy Ramm, Victoria Cornelius, Chris Graham of the Picker Institute Europe.