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.

Taking part in this survey is voluntary. Your answers will be treated in confidence.
Please remember, this questionnaire is about your most recent stay at the hospital named in the accompanying letter.

**ADMISSION TO HOSPITAL**

1. Was your most recent hospital stay planned in advance or an emergency?
   1. Emergency or urgent  ➔ Go to Question 2
   2. Waiting list or planned in advance  ➔ Go to Question 10
   3. Something else ➔ Go to Question 2

**EMERGENCY CARE**

2. Did you travel to the hospital by ambulance?
   1. Yes  ➔ Go to Question 3
   2. No  ➔ Go to Question 6

3. Were the ambulance crew reassuring?
   1. Yes, definitely
   2. Yes, to some extent
   3. No
   4. Don’t know / Can’t remember

4. Did the ambulance crew explain your care and treatment in a way you could understand?
   1. Yes, definitely
   2. Yes, to some extent
   3. No
   4. Don’t know / Can’t remember

5. Did the ambulance crew do everything they could to help control your pain?
   1. Yes, definitely
   2. Yes, to some extent
   3. No
   4. I did not have any pain

**THE EMERGENCY DEPARTMENT**

6. When you arrived at the hospital, did you go to the Emergency Department (Casualty /A&E / Medical or Surgical Admissions unit)?
   1. Yes  ➔ Go to Question 7
   2. No  ➔ Go to Question 10

7. While you were in the Emergency Department, how much information about your condition or treatment was given to you?
   1. Not enough
   2. Right amount
   3. Too much
   4. I was not given any information about my treatment or condition

8. Were you given enough privacy when being examined or treated in the Emergency Department?
   1. Yes, definitely
   2. Yes, to some extent
   3. No
9. Following arrival at the hospital, how long did you wait before being admitted to a bed on a ward?

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

EMERGENCY PATIENTS, now please go to Question 14

WAITING LIST OR PLANNED ADMISSION

10. Were you given a choice of admission dates?

1  ☐ Yes
2  ☐ No
3  ☐ Don’t know / Can’t remember

11. Overall, from the time you were first told you needed to be admitted to hospital, how long did you wait to be admitted?

1  ☐ Up to 1 month
2  ☐ 1 to 3 months
3  ☐ 3 to 6 months
4  ☐ 6 to 9 months
5  ☐ More than 9 months
6  ☐ Don’t know / Can’t remember

12. 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

13. 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

WAITING LIST & PLANNED ADMISSION PATIENTS, please continue to Question 10
ALL TYPES OF ADMISSION

14. 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

15. While in hospital, did you ever stay in a critical care area (Intensive Care Unit, High Dependency Unit or Coronary Care Unit)?

1  [ ] Yes
2  [ ] No
3  [ ] Don’t know / Can’t remember

16. When you were first admitted to a bed on a ward, did you share a sleeping area, for example a room or bay, with patients of the opposite sex?

1  [ ] Yes
2  [ ] No

17. During your stay in hospital, how many wards did you stay in?

1  [ ] 1  ➔ Go to 19
2  [ ] 2  ➔ Go to 18
3  [ ] 3 or more  ➔ Go to 18
4  [ ] Don’t know / Can’t remember  ➔ Go to 19

18. After you moved to another ward (or wards), did you ever share a sleeping area, for example a room or bay, with patients of the opposite sex?

1  [ ] Yes
2  [ ] No

19. While staying in hospital, did you ever use the same bathroom or shower area as patients of the opposite sex?

1  [ ] Yes
2  [ ] Yes, because it had special bathing equipment that I needed
3  [ ] No
4  [ ] I did not use a bathroom or shower
5  [ ] Don’t know / Can’t remember

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

1  [ ] Yes
2  [ ] No

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

1  [ ] Yes
2  [ ] No

22. 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

23. 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
24. How would you rate the hospital food?
   1. Very good
   2. Good
   3. Fair
   4. Poor
   5. I did not have any hospital food

25. Were you offered a choice of food?
   1. Yes, always
   2. Yes, sometimes
   3. No

26. 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

27. Did you have confidence and trust in the doctors treating you?
   1. Yes, always
   2. Yes, sometimes
   3. No

28. Did doctors talk in front of you as if you weren’t there?
   1. Yes, often
   2. Yes, sometimes
   3. No

29. As far as you know, did doctors wash or clean their hands between touching patients?
   1. Yes, always
   2. Yes, sometimes
   3. No
   4. Don’t know / Can’t remember

NURSES

30. 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

31. Did you have confidence and trust in the nurses treating you?
   1. Yes, always
   2. Yes, sometimes
   3. No

32. Did nurses talk in front of you as if you weren’t there?
   1. Yes, often
   2. Yes, sometimes
   3. No
33. 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

34. As far as you know, did nurses wash or clean their hands between touching patients?

1. □ Yes, always
2. □ Yes, sometimes
3. □ No
4. □ Don’t know / Can’t remember

35. 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

36. 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

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

1. □ Not enough
2. □ The right amount
3. □ Too much

38. 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

39. 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

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

1. □ Yes, always
2. □ Yes, sometimes
3. □ No
41. Were you given enough privacy when being examined or treated?

1. Yes, always
2. Yes, sometimes
3. No

42. Did you get enough help from staff to eat your meals?

1. Yes, always
2. Yes, sometimes
3. No
4. I did not need help to eat meals

43. 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

44. Were you ever in any pain?

1. Yes  ➔ Go to Question 45
2. No  ➔ Go to Question 46

45. 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

OPERATIONS & PROCEDURES

46. During your stay in hospital, did you have an operation or procedure?

1. Yes  ➔ Go to Question 47
2. No  ➔ Go to Question 54

47. Beforehand, did a member of staff explain the risks and benefits of the operation or procedure in a way you could understand?

1. Yes, completely
2. Yes, to some extent
3. No
4. I did not want an explanation

48. Beforehand, did a member of staff explain what would be done during the operation or procedure?

1. Yes, completely
2. Yes, to some extent
3. No
4. I did not want an explanation
49. Beforehand, did a member of staff answer your questions about the operation or procedure in a way you could understand?

1. Yes, completely
2. Yes, to some extent
3. No
4. I did not have any questions

50. Beforehand, were you told how you could expect to feel after you had the operation or procedure?

1. Yes, completely
2. Yes, to some extent
3. No

51. Before the operation or procedure, were you given an anaesthetic to put you to sleep or control your pain?

1. Yes  ➔ Go to Question 52
2. No  ➔ Go to Question 53

52. Before the operation or procedure, did the anaesthetist explain how he or she would put you to sleep or control your pain in a way you could understand?

1. Yes, completely
2. Yes, to some extent
3. No

53. After the operation or procedure, did a member of staff explain how the operation or procedure had gone in a way you could understand?

1. Yes, completely
2. Yes, to some extent
3. No

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

1. Yes  ➔ Go to Question 55
2. No  ➔ Go to Question 57

55. 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

56. 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
57. 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 Question 58]
2. Yes, to some extent [Go to Question 58]
3. No [Go to Question 58]
4. I did not need an explanation [Go to Question 58]
5. I had no medicines [Go to Question 60]

58. 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

59. Were you given clear written or printed information about your medicines?

1. Yes, completely
2. Yes, to some extent
3. No
4. Don’t know / Can’t remember

60. 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

61. 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

62. 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

63. Did you receive copies of letters sent between hospital doctors and your family doctor (GP)?

1. Yes, I received copies
2. No, I did not receive copies
3. Not sure / Don’t know

OVERALL

64. 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
65. How would you rate how well the doctors and nurses worked together?
1  □  Excellent
2  □  Very good
3  □  Good
4  □  Fair
5  □  Poor

66. Overall, how would you rate the care you received?
1  □  Excellent
2  □  Very good
3  □  Good
4  □  Fair
5  □  Poor

67. During your hospital stay, were you ever asked to give your views on the quality of your care?
1  □  Yes
2  □  No
3  □  Don’t know / Can’t remember

68. Were you given information on how you could complain about the hospital care you received?
1  □  Yes
2  □  No

69. Are you male or female?
1  □  Male
2  □  Female

70. What was your year of birth?
(Please write in)  e.g.  1 9 3 4

71. 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

72. 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
73. Do you have a long-standing physical or mental health problem or disability?

1. Yes  ➔ Go to 74
2. No  ➔ Go to 75

74. Does this problem or disability affect your day-to-day activities?

1. Yes, definitely
2. Yes, to some extent
3. No

75. 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.
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.

Taking part in this survey is voluntary. Your answers will be treated in confidence.
Please remember, this questionnaire is about your most recent stay at the hospital named in the accompanying letter.

**ADMISSION TO HOSPITAL**

1. Was your most recent hospital stay planned in advance or an emergency?
   - [ ] Emergency or urgent  ➔ Go to Question 2
   - [ ] Waiting list or planned in advance  ➔ Go to Question 10
   - [ ] Something else ➔ Go to Question 2

**EMERGENCY CARE**

2. Did you travel to the hospital by ambulance?
   - [ ] Yes  ➔ Go to Question 3
   - [ ] No  ➔ Go to Question 6

3. Were the ambulance crew reassuring?
   - [ ] Yes, definitely
   - [ ] Yes, to some extent
   - [ ] No
   - [ ] Don't know / Can't remember

4. Did the ambulance crew explain your care and treatment in a way you could understand?
   - [ ] Yes, definitely
   - [ ] Yes, to some extent
   - [ ] No
   - [ ] Don't know / Can't remember

5. Did the ambulance crew do everything they could to help control your pain?
   - [ ] Yes, definitely
   - [ ] Yes, to some extent
   - [ ] No
   - [ ] I did not have any pain

**THE EMERGENCY DEPARTMENT**

6. When you arrived at the hospital, did you go to the Emergency Department (Casualty /A&E / Medical or Surgical Admissions unit)?
   - [ ] Yes  ➔ Go to Question 7
   - [ ] No  ➔ Go to Question 10

7. While you were in the Emergency Department, how much information about your condition or treatment was given to you?
   - [ ] Not enough
   - [ ] Right amount
   - [ ] Too much
   - [ ] I was not given any information about my treatment or condition

8. Were you given enough privacy when being examined or treated in the Emergency Department?
   - [ ] Yes, definitely
   - [ ] Yes, to some extent
   - [ ] No
9. Following arrival at the hospital, how long did you wait before being admitted to a bed on a ward?

- 100 ☐ Less than 1 hour
- 75 ☐ At least 1 hour but less than 2 hours
- 50 ☐ At least 2 hours but less than 4 hours
- 25 ☐ At least 4 hours but less than 8 hours
- 0 ☐ 8 hours or longer
- ☐ Can’t remember
- 100 ☐ I did not have to wait

EMERGENCY PATIENTS, now please go to Question 14

WAITING LIST OR PLANNED ADMISSION

10. Were you given a choice of admission dates?
- 100 ☐ Yes
- 0 ☐ No
- ☐ Don’t know / Can’t remember

11. Overall, from the time you were first told you needed to be admitted to hospital, how long did you wait to be admitted?
- 100 ☐ Up to 1 month
- 75 ☐ 1 to 3 months
- 50 ☐ 3 to 6 months
- 25 ☐ 6 to 9 months
- 0 ☐ More than 9 months
- ☐ Don’t know / Can’t remember

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

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

WAITING LIST & PLANNED ADMISSION PATIENTS, please continue to Question 10
ALL TYPES OF ADMISSION

14. 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

15. While in hospital, did you ever stay in a critical care area (Intensive Care Unit, High Dependency Unit or Coronary Care Unit)?

1 □ Yes
2 □ No
3 □ Don’t know / Can’t remember

16. When you were first admitted to a bed on a ward, did you share a sleeping area, for example a room or bay, with patients of the opposite sex?

01 □ Yes
1002 □ No

17. During your stay in hospital, how many wards did you stay in?

1 □ 1 ➔ Go to 19
2 □ 2 ➔ Go to 18
3 □ 3 or more ➔ Go to 18
4 □ Don’t know / Can’t remember ➔ Go to 19

18. After you moved to another ward (or wards), did you ever share a sleeping area, for example a room or bay, with patients of the opposite sex?

01 □ Yes
1002 □ No

Q18 is scored with Q16. See the scoring notes at Q16 for details.

19. While staying in hospital, did you ever use the same bathroom or shower area as patients of the opposite sex?

01 □ Yes
1002 □ Yes, because it had special bathing equipment that I needed
1003 □ No
- 4 □ I did not use a bathroom or shower
- 5 □ Don’t know / Can’t remember

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

01 □ Yes
1002 □ No

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

01 □ Yes
1002 □ No
22. In your opinion, how clean was the hospital room or ward that you were in?

100 □ Very clean
67 □ Fairly clean
33 □ Not very clean
0 □ Not at all clean

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

100 □ Very clean
67 □ Fairly clean
33 □ Not very clean
0 □ Not at all clean
- □ I did not use a toilet or bathroom

24. How would you rate the hospital food?

100 □ Very good
67 □ Good
33 □ Fair
0 □ Poor
- □ I did not have any hospital food

25. Were you offered a choice of food?

100 □ Yes, always
50 □ Yes, sometimes
0 □ No

DOCTORS

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

100 □ Yes, always
50 □ Yes, sometimes
0 □ No
- □ I had no need to ask

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

100 □ Yes, always
50 □ Yes, sometimes
0 □ No

28. Did doctors talk in front of you as if you weren’t there?

0 □ Yes, often
50 □ Yes, sometimes
100 □ No

29. As far as you know, did doctors wash or clean their hands between touching patients?

100 □ Yes, always
50 □ Yes, sometimes
0 □ No
- □ Don’t know / Can’t remember

NURSES

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

100 □ Yes, always
50 □ Yes, sometimes
0 □ No
- □ I had no need to ask

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

100 □ Yes, always
50 □ Yes, sometimes
0 □ No
32. Did nurses talk in front of you as if you weren’t there?
   - 0: Yes, often
   - 50: Yes, sometimes
   - 100: No

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

34. As far as you know, did nurses wash or clean their hands between touching patients?
   - 100: Yes, always
   - 50: Yes, sometimes
   - 0: No
   - -4: Don’t know / Can’t remember

37. How much information about your condition or treatment was given to you?
   - 0: Not enough
   - 100: The right amount
   - 0: Too much

38. If your family or someone else close to you wanted to talk to a doctor, did they have enough opportunity to do so?
   - 100: Yes, definitely
   - 50: Yes, to some extent
   - 0: 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

39. Did you find someone on the hospital staff to talk to about your worries and fears?
   - 100: Yes, definitely
   - 50: Yes, to some extent
   - 0: No
   - -4: I had no worries or fears

40. Were you given enough privacy when discussing your condition or treatment?
   - 100: Yes, always
   - 50: Yes, sometimes
   - 0: No
41. Were you given enough privacy when being examined or treated?

100  ☐ Yes, always
50  ☐ Yes, sometimes
03  ☐ No

42. Did you get enough help from staff to eat your meals?

100  ☐ Yes, always
50  ☐ Yes, sometimes
03  ☐ No
-  ☐ I did not need help to eat meals

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

100  ☐ 0 minutes/right away
75  ☐ 1-2 minutes
50  ☐ 3-5 minutes
25  ☐ More than 5 minutes
05  ☐ I never got help when I used the call button
-  ☐ I never used the call button

44. Were you ever in any pain?

1  ☐ Yes  ➔ Go to Question 45
2  ☐ No  ➔ Go to Question 46

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

100  ☐ Yes, definitely
50  ☐ Yes, to some extent
03  ☐ No

OPERATIONS & PROCEDURES

46. During your stay in hospital, did you have an operation or procedure?

1  ☐ Yes  ➔ Go to Question 47
2  ☐ No  ➔ Go to Question 54

47. Beforehand, did a member of staff explain the risks and benefits of the operation or procedure in a way you could understand?

100  ☐ Yes, completely
50  ☐ Yes, to some extent
03  ☐ No
-  ☐ I did not want an explanation

48. Beforehand, did a member of staff explain what would be done during the operation or procedure?

100  ☐ Yes, completely
50  ☐ Yes, to some extent
03  ☐ No
-  ☐ I did not want an explanation
49. Beforehand, did a member of staff answer your questions about the operation or procedure in a way you could understand?

100  □ Yes, completely
50  □ Yes, to some extent
0  □ No
-  □ I did not have any questions

50. Beforehand, were you told how you could expect to feel after you had the operation or procedure?

100  □ Yes, completely
50  □ Yes, to some extent
0  □ No

51. Before the operation or procedure, were you given an anaesthetic to put you to sleep or control your pain?

1  □ Yes  ➔ Go to Question 52
2  □ No  ➔ Go to Question 53

52. Before the operation or procedure, did the anaesthetist explain how he or she would put you to sleep or control your pain in a way you could understand?

100  □ Yes, completely
50  □ Yes, to some extent
0  □ No

53. After the operation or procedure, did a member of staff explain how the operation or procedure had gone in a way you could understand?

100  □ Yes, completely
50  □ Yes, to some extent
0  □ No

LEAVING HOSPITAL

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

1  □ Yes  ➔ Go to Question 55
100  □ No  ➔ Go to Question 57

Q54 is used to score Q55 and Q56. See scoring notes under Q55 and Q56 for details.

55. 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
0 □ I had to wait for an ambulance
-  □ Something else

If response to Q54 is 2 (discharge WAS NOT delayed), Q55 is scored 100.

If response to Q54 is 1 (discharge WAS delayed), or if response to Q54 is missing AND response to Q55 is 1, 2, 3 or 4, the scores above are assigned to Q55.

56. How long was the delay?

75  □ Up to 1 hour
50  □ Longer than 1 hour but no longer than 2 hours
25  □ Longer than 2 hours but no longer than 4 hours
0  □ Longer than 4 hours

If response to Q55 is 4 (some other reason for the delay), Q56 is not scored.

If response to Q54 is 2 (discharge WAS NOT delayed), Q56 is scored 100.

If response to Q54 is 1 (discharge WAS delayed), or missing AND the response to Q55 is 1, 2 or 3, the scores above are assigned to Q56. If response to Q54 is 1 (discharge WAS delayed) and the response to Q55 is missing, Q56 is not scored.
57. Did a member of staff explain the purpose of the medicines you were to take at home in a way you could understand?

100 ☐ Yes, completely ➔ Go to Question 58

50 ☐ Yes, to some extent ➔ Go to Question 58

03 ☐ No ➔ Go to Question 58
-

☐ I did not need an explanation ➔ Go to Question 58
-

☐ I had no medicines ➔ Go to Question 60

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

100 ☐ Yes, completely

50 ☐ Yes, to some extent

03 ☐ No
-

☐ I did not need an explanation
-

59. Were you given clear written or printed information about your medicines?

100 ☐ Yes, completely

50 ☐ Yes, to some extent

03 ☐ No
-

☐ I did not need an explanation

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

100 ☐ Yes, completely

50 ☐ Yes, to some extent

03 ☐ No
-

☐ It was not necessary
-

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

100 ☐ Yes, definitely

50 ☐ Yes, to some extent

03 ☐ No
-

☐ No family or friends were involved
-

☐ My family or friends did not want or need information

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

100 ☐ Yes

02 ☐ No
-

☐ Don’t know / Can’t remember

63. Did you receive copies of letters sent between hospital doctors and your family doctor (GP)?

100 ☐ Yes, I received copies

02 ☐ No, I did not receive copies
-

☐ Not sure / Don’t know

OVERALL

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

100 ☐ Yes, always

50 ☐ Yes, sometimes

03 ☐ No
65. How would you rate how well the doctors and nurses worked together?

100  □ Excellent
752  □ Very good
503  □ Good
254  □ Fair
05   □ Poor

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

100  □ Excellent
752  □ Very good
503  □ Good
254  □ Fair
05   □ Poor

67. During your hospital stay, were you ever asked to give your views on the quality of your care?

100  □ Yes
02   □ No
- 3  □ Don’t know / Can’t remember

68. Were you given information on how you could complain about the hospital care you received?

100  □ Yes
02   □ No

ABOUT YOU

69. Are you male or female?

1 □ Male
2 □ Female

70. What was your year of birth?

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

71. 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

72. 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
73. Do you have a long-standing physical or mental health problem or disability?

1. Yes  ➔ Go to 74
2. No  ➔ Go to 75

74. Does this problem or disability affect your day-to-day activities?

1. Yes, definitely
2. Yes, to some extent
3. No

75. 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.
Non survey variable definitions: In Patient 2006 survey data

1. trustcode: Trust code (see 2006 Inpatients survey trust list.xls)
2. trustnum: Trust number (see 2006 Inpatients survey trust list.xls)
3. LOS: Length of stay
4. age_group: Age calculated from year of birth and then banded.
5. outcome: Outcome of sending questionnaire
   • Returned useable questionnaire=1
   • Returned undelivered or pt moved house=2
   • Patient 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
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

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

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 (i.e., 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 patients 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. 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

---

1 This involves sorting the sample frame based on some critical dimension(s) – e.g., 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. 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. 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>
<thead>
<tr>
<th>University</th>
<th>No. students</th>
<th>Proportion smoking</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>10000</td>
<td>0.2</td>
</tr>
<tr>
<td>B</td>
<td>8000</td>
<td>0.3</td>
</tr>
<tr>
<td>C</td>
<td>1000</td>
<td>0.6</td>
</tr>
<tr>
<td>Regional total</td>
<td>19,000</td>
<td></td>
</tr>
</tbody>
</table>

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:

\[W_{iq} = \frac{n_q}{n_{iq}}\]

*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:

\[
\text{trust mean} = \frac{(0.2 + 0.23 + 0.3)}{3} = 0.2433
\]

**Table 3 Weighting to trust population**

<table>
<thead>
<tr>
<th>Trust</th>
<th>No. responders to food question in trust ((n_{iq}))</th>
<th>Proportion of respondents disliking the food</th>
<th>Weight</th>
<th>(1 \times 2 \times 3)</th>
<th>(1 \times 3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>X</td>
<td>600</td>
<td>0.2</td>
<td>0.7778</td>
<td>93.333333</td>
<td>466.6667</td>
</tr>
<tr>
<td>Y</td>
<td>500</td>
<td>0.23</td>
<td>0.9333</td>
<td>107.333333</td>
<td>466.6667</td>
</tr>
<tr>
<td>Z</td>
<td>300</td>
<td>0.3</td>
<td>1.5556</td>
<td>140</td>
<td>466.6667</td>
</tr>
<tr>
<td>All</td>
<td>1400</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean</td>
<td>466.6667</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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:

\[
\text{trust weight} = \frac{\text{mean value of } n_{iq}}{n_{iq}}.
\]

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:

 numerador for proportion \(= (600 \times 0.2 \times 0.7778) + (500 \times 0.23 \times 0.9333) + (300 \times 0.3 \times 1.5556) = 340.6667\)

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

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 \( n_{cases} \))/ \( n_{cases} \) (where \( n_{cases} \) 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 between 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 \( i \) (\( n_{q} \)) is less than \( n_{cases} \). 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 \( n_{cases} \). 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 \( n_{q} \). 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:

<table>
<thead>
<tr>
<th>Patients</th>
<th>Trusts</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
• 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:

\[ \text{patient population weight} = \frac{k \times N_i}{n_{\text{cases}}} \]

where:
- \( n_{\text{cases}} \) is the number of respondents in trust \( i \)
- \( N_i \) 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,

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

\[
\text{trust weight} = \frac{\text{mean value of } n_{\text{cases}}}{n_{\text{cases}}}
\]

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 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

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\(^6\) 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.
GUIDANCE ON DATA CLEANING FOR THE NHS ADULT INPATIENTS SURVEY 2006

THE ACUTE CO-ORDINATION CENTRE FOR THE NHS ACUTE PATIENT SURVEY PROGRAMME

Last updated: 1st February 2007
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Updates

Before you use this document, check that you have the latest version, 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 and contractors directly to inform them of the change.

This document is available from the Acute Co-ordination Centre website at:

www.NHSSurveys.org

Questions and comments

If you have any questions or concerns regarding this document, or if you have any specific queries regarding the submission of data, please contact the Acute Co-ordination Centre:

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By phone: 01865 208127

1 Previously the NHS Patient Survey Advice Centre
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1 Inpatient Survey 2006 – data cleaning

1.1 Introduction

Once fieldwork for the 2006 national inpatient survey has been completed, participating trusts and contractors will be required to submit data to the Acute Co-ordination Centre in a raw (uncleaned) format. Following this, data for all trusts in the survey will be collated and the full dataset will be cleaned together to ensure that cleaning taking place on data pertaining to different trusts is comparable.

This document provides a description and specification of the processes that will be used by the Acute Co-ordination Centre to clean and standardise data submitted by contractors and trusts as part of the 2006 national survey of inpatients. By following the guidance contained in this document, it should be possible to recreate this cleaning process.

If you have any comments or queries regarding this document please contact the Acute Co-ordination Centre on 01865 208 127, or e-mail us at acute@pickereurope.ac.uk.

1.2 The core and extended questionnaires

For the 2006 national inpatient survey, all trusts have the option to use either the 75 item ‘core’ questionnaire or to use an extended questionnaire with further questions available from the ‘question bank’ for the survey. The Acute Co-ordination Centre only requires data to be submitted for the 75 core items, and so all cleaning undertaken by ourselves will involve only these 75 core items. As such, this document looks only at the cleaning required for the core survey.

Nonetheless, the rules and principles of data cleaning described here can be applied to data from an extended questionnaire, so long as careful attention is paid to question numbers and so on.

1.3 Definitions

Definitions of terms commonly used in this document, as they apply to the National Survey of Adult Inpatients 2006 are as follows:

Raw/uncleaned data: ‘Raw’ or ‘uncleaned’ data is data that has been entered verbatim from completed questionnaires without any editing taking place to remove contradictory or inappropriate responses; thus, all responses ticked on the questionnaire should be included in the data entry spreadsheet, except where multiple responses have been ticked or in some instances where year of birth has been entered in an incorrect format (see Section 2: Submitting raw (‘uncleaned’) data, for detailed guidance on submitting raw data). The requirement for raw/uncleaned data does not, however, preclude the checking of data for errors resulting from problems with data entry or similar. Ensuring high data quality is paramount and errors resulting from data entry problems can and should be corrected by checking against the appropriate completed questionnaire.

---

2 Responses ticked on the questionnaire should not be included in the data entry sheet where:
   a) multiple responses have been ticked - set these to missing
   b) year of birth has been entered in incorrect format - if the patient’s intended response is unambiguous from the questionnaire, then enter this.
Data cleaning: The Acute Co-ordination Centre uses the term ‘data cleaning’ to refer to all editing processes undertaken upon survey data once the survey has been completed and the data has been entered and collated.

Routing questions: These are items on the questionnaire which instruct respondents to either continue on to the next question or to skip past irrelevant questions depending on their response to the routing question. For the 2006 national survey of inpatients, the routing questions in the core questionnaire are Q1, Q2, Q6, Q17, Q24, Q44, Q46, Q51, Q54, Q57, and Q73.

Filtered questions: Items on the questionnaire that are not intended to be answered by all respondents are referred to as ‘filtered’ questions. Whether individual respondents are expected to answer filtered questions depends on their responses to preceding routing questions. For the 2006 national survey of inpatients, the filtered questions in the core questionnaire are Q2—Q13, Q18, Q25, Q45, Q47—Q53, Q55—Q56, Q58—Q59, and Q74.

Non-filtered questions: these are items in the questionnaire which are not subject to any routing/filtering and which should therefore be answered by all respondents. For the 2006 national survey of inpatients, the non-filtered questions are Q1, Q14—Q17, Q19—Q24, Q26—Q44, Q46, Q54, Q57, Q60—Q73, Q75.

Out-of-range data: This refers to instances where data within a variable has a value that is not permissible. For categorical data – as in the case of the majority of variables in this survey – this would mean a value not allowed in the data, for example, a value of ‘3’ being entered in a variable with only two response categories (1 or 2). For scalar data – eg year of birth – data is considered to be out-of-range if it specifies a value that is not possible (for instance, year of birth as 983 or 2983). Out-of-range responses entered into the dataset should not be automatically (eg, algorithmically) removed prior to submitting the data to the Acute Co-ordination Centre (see Section 2: Submitting raw (‘uncleaned’) data).

Non-specific response: This is a loose term for response options that can be considered as not being applicable to the respondent in terms of directly answering the specific question to which they are linked. Most commonly, these are responses such as “don’t know/can’t remember”, which indicate a failure to recall the issue in question. Likewise, responses that indicate the question is not applicable to the respondent are considered ‘non-specific’ – for example, responses such as “I did not have any food” or “I did not use any bathrooms”. A full listing of such responses for the 2006 inpatient survey can be found in Appendix B: Non-specific responses.

---

3 The range Q2-Q13 includes four separate sets of filtered questions; Q2-Q9, Q3-Q5, Q7-Q9, and Q10-Q13.
4 The range Q47-Q53 includes two separate sets of filtered questions; Q47–Q53, and Q52.
2 Submitting raw (‘uncleaned’) data

For the 2006 national inpatient survey, trusts and contractors are required to submit raw (‘uncleaned’) data to the Acute Co-ordination Centre. For clarification, raw data is created as follows:

i All responses should be entered into the dataset, regardless of whether or not the respondent was meant to respond to the question (eg, where patients answer questions that they have been directed to skip past, these responses should still be entered).

ii Where a respondent has ticked more than one response category on a question, this should be set to ‘missing’ in the data.

iii Where a respondent has crossed out a response, this should not be entered in the data. Where a respondent has crossed out a response and instead ticked a second response option, this second choice should be entered into the data.

iv Where a respondent has given their response inconsistently with the formatting of the questionnaire but where their intended response is nonetheless unambiguous on inspection of the completed questionnaire, then the respondent’s intended response should be entered. For example, where a patient has written their date of birth in the boxes for Q70, but written their year of birth in at the side of this, then the respondent’s year of birth should be entered.

v For the year of birth question, unrealistic responses should still be entered except following iv above). For example, if a respondent enters ‘2006’ in the year of birth box, this should still be entered unless the respondent has unambiguously indicated their actual year of birth to the side.

vi Once the data has been entered, no responses should be removed or changed in any way except where responses are known to have been entered incorrectly or where inspection of the questionnaire indicates that the patient’s intended response has not been captured. This includes ‘out-of-range’ responses, which must not be automatically removed from the dataset. Responses in the dataset should only be changed before submission to the Acute Coordination Centre where they are found to have been entered inconsistently with the respondent’s intended response.
3 Editing/cleaning data after submission

3.1 Approach and rationale

The purpose of the Acute Co-ordination Centre in cleaning the data submitted to us is to ensure an optimal balance of data quality and completeness. Thus, we seek to remove responses that are known to be erroneous or inappropriate but do this in a relatively permissive way so as to enable as many responses as possible to contribute to the overall survey results.

3.2 Filters

Some of the questions included in the survey are only relevant to a subset of respondents, and in these cases filter instructions on the questionnaire are used to route respondents past questions that are not applicable to them. For example, people who tick “no” to Q2 (“Did you travel to the hospital by ambulance?”) are instructed to skip all further questions on ambulances (e.g. Q3, Q4, and Q5).

It is necessary to clean the data to remove inappropriate responses where filter instructions have been incorrectly followed. In such cases, participants’ responses to questions that were not relevant to them are deleted from the dataset. Responses are only deleted where respondents have answered ‘filtered’ questions despite ticking an earlier response on a routing question instructing them to skip these questions (e.g. a respondent ticking “No” to Q2 but then answering the three questions about the ambulance crew as in the example above). Responses to ‘filtered’ questions are not removed where the response to the routing question is missing. For example, Q2-Q9 are filtered by the response to Q1 (e.g. if Q1=2), but if a respondent does not answer Q1, or if the Q1 response is missing for any reason, then responses to Q2-Q9 should not be removed.

Figure 1 (overleaf) shows a summary of all routing questions, and the filtered questions they relate to, that are included on the 2006 national inpatient survey. Please note that these instructions should be followed sequentially in order to be consistent with the procedures applied by the Acute Co-ordination Centre.
**Figure 1 - List of routing/filtering instructions**

<table>
<thead>
<tr>
<th>ROUTING QUESTION</th>
<th>RESPONSE VALUES</th>
<th>FILTERED QUESTIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>if Q1 = 2</td>
<td>then delete responses to: Q2 - Q9</td>
<td></td>
</tr>
<tr>
<td>if Q2 = 2</td>
<td>then delete responses to: Q3 - Q5</td>
<td></td>
</tr>
<tr>
<td>if Q6 = 1</td>
<td>then delete responses to: Q10 - Q13</td>
<td></td>
</tr>
<tr>
<td>if Q6 = 2</td>
<td>then delete responses to: Q7 - Q9</td>
<td></td>
</tr>
<tr>
<td>if Q17 = 1 OR 4</td>
<td>then delete responses to: Q18</td>
<td></td>
</tr>
<tr>
<td>if Q24 = 5</td>
<td>then delete responses to: Q25</td>
<td></td>
</tr>
<tr>
<td>if Q44 = 2</td>
<td>then delete responses to: Q45</td>
<td></td>
</tr>
<tr>
<td>if Q46 = 2</td>
<td>then delete responses to: Q47 - Q53</td>
<td></td>
</tr>
<tr>
<td>if Q51 = 2</td>
<td>then delete responses to: Q52</td>
<td></td>
</tr>
<tr>
<td>if Q54 = 2</td>
<td>then delete responses to: Q55 - Q56</td>
<td></td>
</tr>
<tr>
<td>if Q57 = 5</td>
<td>then delete responses to: Q58 - Q59</td>
<td></td>
</tr>
<tr>
<td>if Q73 = 2</td>
<td>then delete responses to: Q74</td>
<td></td>
</tr>
</tbody>
</table>

Please note that these instructions should be followed sequentially in the order shown above.

Please note that Q1 should not be considered a branching question in the traditional sense – for example, responses to Q10-Q13 – the questions on planned admissions – must not be automatically removed if Q1=1. It should be noted from the questionnaire that even though patients responding “emergency or urgent” to Q1 are identifying themselves as emergency admissions, they may subsequently report not having been to an Emergency Department as part of their admission – eg if Q6=2 – and that in such cases they are then asked to continue from Q10. Thus, not all respondents ticking Q1=1 will be expected to skip Q10-Q13.

A worked example of the cleaning process for removing unexpected responses to filtered questions is included in Appendix A: Example of cleaning.

### 3.3 Dealing with demographics

Basic demographic information, including age, sex, and ethnicity of patients are included in the sample section of the data, but the ‘About You’ section at the end of the questionnaire also asks respondents to provide this information. In a minority of cases, the information provided from the sample frame and by the respondents does not correspond – for example, the sample may identify an individual as male only for them to report being female (eg Q69=2).

Because of this, and because questions about demographics tend to produce relatively high item non-response rates, it is not appropriate to rely on either source of data alone.

Where responses to demographic questions are present, it is assumed these are more likely to be accurate than sample frame information (since it is assumed that respondents are best placed to know their own sex, age, and ethnic group). Where responses to demographic questions are missing, however, sample data are used in their place.

---

5 Please note though that respondents will not be considered ineligible for the survey solely on the basis of their response to the year of birth question indicating that they are under the age of sixteen. This is because of the difficulty of inferring the source of errors when year of birth from sample and response sections are mismatched – in other words, because we cannot be certain whether this mismatch occurs [see overleaf]
For demographic analysis on groups of cases, then, it is necessary to use some combination of the information supplied in the sample frame and by the respondents. To do this, we first copy all valid responses to survey demographic questions into a new variable. Where responses are missing we then copy in the relevant sample information (note that for a very small number of patients demographic information may be missing in both the sample and response sections; in such cases data must necessarily be left missing in the new variable).

Certain demographic variables require special consideration during data cleaning:

**Age (Q70)**
A common error when completing year of birth questions on forms is for respondents to accidentally write in the *current* year – thus responses to Q70 of ‘2006’ will be set to missing during cleaning. Out-of-range responses will also be set to missing. For the 2006 national inpatient survey, out-of-range responses are defined as \(Q70 \leq 1880 \text{ OR } Q70 \geq 2006\).

**Ethnic group (Q75)**
When merging sample and response data the ethnic group variables ('Ethnic' and 'Q75' respectively) present a particular problem as different categories are used in these variables. In order to combine data from these two variables, then, it is necessary to reduce the 16 categories from Q75 into six broader categories as used in the sample section. Figure 2 (below) shows how values should be recoded to be consistent with the mapping used by the Acute Co-ordination Centre.

Also note that it is generally not appropriate to merge ethnicity values for response rate analysis because of the systematic ‘migration’ of ethnic group categorisations between sample and response. Put another way; because the categories used in the sample section are relatively broad, and because people tend to have highly specific conceptions of their own ethnic group, there is a tendency for respondents from certain backgrounds to report an apparently different ethnicity to that which is recorded on the sample frame. A particular issue is patients coded as ‘any other ethnic group’. Although in the context of the six categories used in the sample frame this may often be considered an appropriate categorisation, it is seldom one people choose for themselves – respondents are more likely, if their ethnic group is not closely matched by an available response options, to choose one of the ‘any other White/Mixed/Asian/Black background’ options positioned earlier in the questionnaire structure than to select the 16th option, ‘any other ethnic group’. If data from the sample and response sections are merged, then, this can have the effect of giving an unrealistically low response rate for patients coded on the sample frame as ‘any other ethnic group’ – this happens because the majority of such patients who do respond would be ‘moved out’ of this sub-group by virtue of their response to Q75, whilst for non-responders the initial coding must by definition be preserved. Thus, **any reporting of response rates by ethnic**

---

6 The majority of out-of range responses present in data relating to year of birth questions result from errors in data entry (for example, not keying one of the digits – so ‘1983’ may become 983, 183, 193, or 198). In such cases it is important that the responses be checked against the completed questionnaire forms, and data corrected if necessary, **prior** to submission of data to the Co-ordination Centre.

7 This refers to the instability between categorisations of ethnic group given in sample and response data – the term ‘migration’ is used to emphasise the perceived shift in the ethnic composition of the achieved sample when looking at response compared to sample data.
group should be based on sample information only. For sub-group analysis of responses, though, it is generally more appropriate to base categories on patients' responses to Q75.

**Figure 2: Mapping ethnic group responses to sample data**

<table>
<thead>
<tr>
<th>Value</th>
<th>Label</th>
<th>Value</th>
<th>Label</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>White British</td>
<td>1</td>
<td>White</td>
</tr>
<tr>
<td>2</td>
<td>White Irish</td>
<td>2</td>
<td>Mixed</td>
</tr>
<tr>
<td>3</td>
<td>Any other White background</td>
<td>3</td>
<td>Asian or Asian British</td>
</tr>
<tr>
<td>4</td>
<td>White and Black Caribbean</td>
<td>4</td>
<td>Black or Black British</td>
</tr>
<tr>
<td>5</td>
<td>White and Black African</td>
<td>5</td>
<td>Chinese</td>
</tr>
<tr>
<td>6</td>
<td>White and Asian</td>
<td>6</td>
<td>Other ethnic group</td>
</tr>
<tr>
<td>7</td>
<td>Any other Mixed background</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Indian</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Pakistani</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Bangladeshi</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Any other Asian background</td>
<td>11</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Caribbean</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>African</td>
<td>13</td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>Any other Black background</td>
<td>14</td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>Chinese</td>
<td>15</td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>Any other ethnic group</td>
<td>16</td>
<td></td>
</tr>
</tbody>
</table>

3.4 Usability and eligibility

Sometimes questionnaires are returned with only a very small number of questions completed. For the inpatient survey 2006, questionnaires containing fewer than five responses are considered ‘unusable’ – we will delete all responses pertaining to such cases and outcome codes of 1 (‘returned useable questionnaire’) relating to these cases will be changed to 6 (‘questionnaire not returned’). Please note that the number of responses per questionnaire will be counted after all other cleaning, and that all responses remaining at this stage will be counted (including responses to the demographic questions and so on). This should only affect a very limited number of cases, and so should not have a significant impact on response rates.

Outcome codes for respondents will also be changed if the respondents are believed to be under the age of sixteen and therefore ineligible for participation. Since the sample files for the survey are to be checked by the Acute Co-ordination Centre prior to mailing, this is unlikely to affect more than a handful of cases throughout the survey, as patients coded as being aged under 16 will be identified and removed from the sample before the start of the survey. Sample members will not, however, be removed from the sample if data on their year of birth is missing from the sampling frame. If sample information on a respondent’s year of birth is missing, though, and their response
to Q75 indicates that they are under 16 (specifically, if Q75 ≥ 1991) then the outcome code for that patient should be recoded from 1 (‘returned completed questionnaire’) to 5 (‘ineligible for participation in the survey’). This should only be done where sample information is missing. If sample information indicates a patient is aged 16 or over, but this is contradicted by the patient’s response, then the patient’s survey outcome should remain as 1. This is to avoid removing legitimate responses because of an overly conservative approach to assessing eligibility; in other words, where the patient’s age is uncertain (because sample and response information contradict each other, and in different instances either of these may be accurate or inaccurate) the benefit of the doubt is given in any assessment of eligibility.

3.5 Missing responses

It is useful to be able to see the numbers of respondents who have missed each question for whatever reason. Responses are considered to be missing when a respondent is expected to answer a question but no response is present. For non-filtered questions, responses are expected from all respondents – thus any instance of missing data constitutes a missing response. For filtered questions, only respondents who have answered a previous routing question instructing them to go on to that filtered question or set of filtered questions are expected to give answers. Where respondents to the survey have missed a routing question, they are not expected to answer subsequent ‘filtered’ questions; thus only where respondents were explicitly instructed to answer filtered questions should such blank cells be coded as missing responses.

The Acute Co-ordination Centre codes missing responses in the data with the value 9998. For results to be consistent with those produced by the Acute Co-ordination Centre, missing responses should be presented but should not be included in the base number of respondents for percentages.

3.6 Non-specific responses

As well as excluding missing responses from results, the Acute Co-ordination Centre also removes non-specific responses from base numbers for percentages. The rationale for this is to facilitate easy comparison between institutions by presenting only results from those patients who felt able to give an evaluative response to questions. For a full listing of ‘non-specific’ responses in the 2006 national inpatient survey, please see Appendix B.

---

8 This is an arbitrary value chosen because it is ‘out-of-range’ for all other questions on the survey.
4 Appendix A: Example of cleaning

4.1 Incorrectly followed routing

Figure 3: Example ‘raw’/’uncleaned’ data

<table>
<thead>
<tr>
<th>Record</th>
<th>Outcome</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>Q5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Record Number</td>
<td>Outcome of sending questionnaire (N)</td>
<td>Was your most recent hospital stay planned in advance or an emergency?</td>
<td>Did you travel to the hospital by ambulance?</td>
<td>Were the ambulance crew reassuring?</td>
<td>Did the ambulance crew explain your care and treatment in a way you could understand?</td>
<td>Did the ambulance crew do everything they could to help control your pain?</td>
</tr>
<tr>
<td>A</td>
<td>6</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B</td>
<td>1</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D</td>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>E</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td></td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>F</td>
<td>6</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>4</td>
</tr>
<tr>
<td>G</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>H</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

Figure 3 shows hypothetical raw/uncleaned data for eight sample members, five of whom have responded to the survey. It can be seen from this data that some of the respondents have followed filter instructions from routing questions incorrectly:

- Respondent ‘G’ has reported that their admission to hospital was planned or from a waiting list (Q1=2), but has responded to filtered questions Q2, Q3, Q4 and Q5.
- Respondents ‘E’ and ‘H’ have reported that they did not travel to hospital in an ambulance (Q2=2) but have both responded to filtered questions about care by the ambulance crew (‘E’ has answered Q5, whilst ‘H’ has answered Q3, Q4, and Q5).

Following the cleaning instructions above will remove these inappropriate responses. Firstly, the filter instructions specify that:

if \[ Q1 = 2 \] then delete responses to: Q2 - Q9

In accordance with this, all responses for Q2, Q3, Q4, Q5, Q6, Q7, Q8, and Q9 must be removed in cases where the respondent has ticked Q1=2 (‘waiting list or planned in advance’). Looking in column Q1 we can see that two respondents, ‘B’ and ‘G’, have ticked Q1=2, so any responses they gave to questions two through to nine should be removed. This will lead to four responses (to Q2, Q3, Q4, and Q5) being removed for respondent ‘G’, who has for whatever reason followed the routing instructions incorrectly and continued to answer the section on emergency care. It should be noted that respondent ‘G’s response to Q3, Q4, and Q5 – questions on ambulance care – have been removed even though that respondent had reported travelling to hospital in an ambulance
(e.g. Q2=1). This is because the earlier routing instructions instruct respondents to skip Q2-9 if Q1=2, as is the case here\(^9\).

Secondly, the filter instructions specify that:

| Q2 | then delete responses to: Q3 - Q5 |

Thus all responses for Q3, Q4, and Q5 should be removed in cases where Q2=2 (not conveyed by ambulance). Looking at the data in column Q2, it can be seen that this applies to respondents ‘E’ and ‘H’. This means that the response to Q5 from ‘E’ should be removed, as should responses to Q3, Q4, and Q5 from ‘H’.

Figure 4 (below) shows how the data would look following cleaning by the co-ordination centre to remove responses to filtered questions that should have been skipped – cells where responses have been removed are shaded.

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\(^9\) Whilst some waiting list/planned admission patients will arrive via an ambulance of some kind, the survey is specifically interested only in the care provided by emergency and urgent ambulance services – not that provided by non-urgent ambulances such as patient transport services (PTS) or ambulance car services (ACS).
## 5 Appendix B: Non-specific responses

The following table lists all 'non-specific responses' included in the 2006 inpatient survey. Please note that this table also includes items from the question bank which are not included in the minimal ‘core’ questionnaire. Numbers in the final column indicate the response options that should be considered non-specific. Where the ‘non-specific responses’ column contains only a dash, the relevant question has no such response options.

<table>
<thead>
<tr>
<th>CORE</th>
<th>BANK</th>
<th>Question</th>
<th>Non-specific responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1</td>
<td>A1</td>
<td>Was your most recent hospital stay planned in advance or an emergency?</td>
<td>-</td>
</tr>
<tr>
<td>Q2</td>
<td>A2</td>
<td>Did you travel to the hospital by ambulance?</td>
<td>-</td>
</tr>
<tr>
<td>Q3</td>
<td>A3</td>
<td>Were the ambulance crew reassuring?</td>
<td>4</td>
</tr>
<tr>
<td>Q4</td>
<td>A4</td>
<td>Did the ambulance crew explain your care and treatment in a way you could understand?</td>
<td>4</td>
</tr>
<tr>
<td>Q5</td>
<td>A5</td>
<td>Did the ambulance crew do everything they could to help control your pain?</td>
<td>4</td>
</tr>
<tr>
<td>Q6</td>
<td>A6</td>
<td>Overall, did the ambulance crew treat you with respect and dignity?</td>
<td>4</td>
</tr>
<tr>
<td>Q7</td>
<td>A7</td>
<td>When you arrived at the hospital, did you go to the Emergency Department (Casualty/AндE/Medical or Surgical Admissions unit)?</td>
<td>-</td>
</tr>
<tr>
<td>Q8</td>
<td>A8</td>
<td>How organised was the care you received in the emergency department?</td>
<td>-</td>
</tr>
<tr>
<td>Q9</td>
<td>A9</td>
<td>While you were in the Emergency Department, did you get enough information about your medical condition and treatment?</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>A10</td>
<td>For most of the time, were you waiting in…?</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>A11</td>
<td>For most of the time, were you waiting on…?</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>A12</td>
<td>Did you think the order in which patients were seen in the Emergency Department was fair?</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>A13</td>
<td>While you were in the Emergency Department, how much information about your condition or treatment was given to you?</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>A14</td>
<td>Were you given enough privacy when being examined or treated in the Emergency Department?</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>A15</td>
<td>Following arrival at the hospital, how long did you wait before being admitted to a bed on a ward?</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>A16</td>
<td>Were you given a choice about which hospital you were admitted to?</td>
<td>3, 4</td>
</tr>
<tr>
<td></td>
<td>A17</td>
<td>Overall, did you get enough information about the different hospitals to make your choice?</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>A18</td>
<td>Other than your local hospital, how many choices of hospital were you given?</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>A19</td>
<td>Was the information about different hospitals easy to understand?</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>A20</td>
<td>Were you given a choice of admission dates?</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>A21</td>
<td>Overall, from the time you were first told you needed to be admitted to hospital, how long did you wait to be admitted?</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>A22</td>
<td>How do you feel about the length of time you were on the waiting list before your admission to hospital?</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>A23</td>
<td>When you were told you would be going into hospital, were you given enough notice of your date of admission?</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>A24</td>
<td>Was your admission date changed by the hospital?</td>
<td>-</td>
</tr>
<tr>
<td>CORE</td>
<td>BANK</td>
<td>Question</td>
<td>Non-specific responses</td>
</tr>
<tr>
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<td>-------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>A25</td>
<td></td>
<td>Before being admitted to hospital, were you given any printed information about the hospital?</td>
<td>-</td>
</tr>
<tr>
<td>A26</td>
<td></td>
<td>Before being admitted to hospital, were you given any printed information about your condition or treatment?</td>
<td>-</td>
</tr>
<tr>
<td>A27</td>
<td></td>
<td>Before you were admitted, were you invited to visit the hospital to meet the staff?</td>
<td>4</td>
</tr>
<tr>
<td>A28</td>
<td></td>
<td>Did visiting the hospital and meeting the staff help you when you were actually admitted?</td>
<td>-</td>
</tr>
<tr>
<td>A29</td>
<td></td>
<td>How organised was the admission process?</td>
<td>-</td>
</tr>
<tr>
<td>Q14</td>
<td></td>
<td>A30 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?</td>
<td>-</td>
</tr>
<tr>
<td>A31</td>
<td></td>
<td>Did a member of staff explain why you had to wait?</td>
<td>-</td>
</tr>
<tr>
<td>A32</td>
<td></td>
<td>How would you rate the courtesy of the staff who admitted you?</td>
<td>-</td>
</tr>
<tr>
<td>Q15</td>
<td></td>
<td>B1 While in hospital, did you ever stay in a critical care area (Intensive Care Unit, High Dependency Unit or Coronary Care Unit)?</td>
<td>3</td>
</tr>
<tr>
<td>Q16</td>
<td></td>
<td>B2 When you were first admitted to a bed on a ward, did you share a sleeping area, for example a room or bay, with patients of the opposite sex?</td>
<td>-</td>
</tr>
<tr>
<td>B3</td>
<td></td>
<td>Were you ever bothered or upset by having to share a room or bay with patients of the opposite sex?</td>
<td>-</td>
</tr>
<tr>
<td>Q17</td>
<td></td>
<td>B4 During your stay in hospital, how many wards did you stay in?</td>
<td>4</td>
</tr>
<tr>
<td>B5</td>
<td></td>
<td>Did you find it upsetting to be moved from one room to another?</td>
<td>-</td>
</tr>
<tr>
<td>Q18</td>
<td></td>
<td>B6 After you moved to another ward (or wards), did you ever share a sleeping area, for example a room or bay, with patients of the opposite sex?</td>
<td>-</td>
</tr>
<tr>
<td>Q19</td>
<td></td>
<td>B7 While staying in the hospital, did you ever use the same bathroom or shower area as patients of the opposite sex?</td>
<td>4, 5</td>
</tr>
<tr>
<td>B8</td>
<td></td>
<td>For most of your stay, what type of room or ward were you in?</td>
<td>-</td>
</tr>
<tr>
<td>B9</td>
<td></td>
<td>When you reached the ward, did you get enough information about ward routines, such as timetables and rules?</td>
<td>4</td>
</tr>
<tr>
<td>B10</td>
<td></td>
<td>Were you ever bothered by noise during the day from other patients?</td>
<td>-</td>
</tr>
<tr>
<td>B11</td>
<td></td>
<td>Were you ever bothered by noise during the day from hospital staff?</td>
<td>-</td>
</tr>
<tr>
<td>Q20</td>
<td></td>
<td>B12 Were you ever bothered by noise at night from other patients?</td>
<td>-</td>
</tr>
<tr>
<td>Q21</td>
<td></td>
<td>B13 Were you ever bothered by noise at night from hospital staff?</td>
<td>-</td>
</tr>
<tr>
<td>Q22</td>
<td></td>
<td>B14 In your opinion, how clean was the hospital room or ward that you were in?</td>
<td>-</td>
</tr>
<tr>
<td>Q23</td>
<td></td>
<td>B15 How clean were the toilets and bathrooms that you used in hospital?</td>
<td>5</td>
</tr>
<tr>
<td>Q24</td>
<td></td>
<td>B16 How would you rate the hospital food?</td>
<td>5</td>
</tr>
<tr>
<td>B17</td>
<td></td>
<td>Was there healthy food on the hospital menu?</td>
<td>4</td>
</tr>
<tr>
<td>B18</td>
<td></td>
<td>How much food were you given?</td>
<td>-</td>
</tr>
<tr>
<td>Q25</td>
<td></td>
<td>B19 Were you offered a choice of food?</td>
<td>-</td>
</tr>
<tr>
<td>B20</td>
<td></td>
<td>Did you get the food you ordered?</td>
<td>-</td>
</tr>
<tr>
<td>B21</td>
<td></td>
<td>How would you rate the courtesy of the catering staff?</td>
<td>-</td>
</tr>
<tr>
<td>B22</td>
<td></td>
<td>How would you rate the courtesy of the hospital porters?</td>
<td>-</td>
</tr>
<tr>
<td>B23</td>
<td></td>
<td>How would you rate the courtesy of the cleaning staff?</td>
<td>-</td>
</tr>
<tr>
<td>C1</td>
<td></td>
<td>Was there one doctor in overall charge of your care?</td>
<td>3</td>
</tr>
<tr>
<td>Q26</td>
<td></td>
<td>C2 When you had important questions to ask a doctor, did you get answers that you could understand?</td>
<td>4</td>
</tr>
<tr>
<td>CORE</td>
<td>BANK</td>
<td>Question</td>
<td>Non-specific responses</td>
</tr>
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</tr>
<tr>
<td>C3</td>
<td></td>
<td>If you had any worries or fears about your condition or treatment, did a doctor discuss them with you?</td>
<td>4</td>
</tr>
<tr>
<td>Q27</td>
<td>C4</td>
<td>Did you have confidence and trust in the doctors treating you?</td>
<td>-</td>
</tr>
<tr>
<td>Q28</td>
<td>C5</td>
<td>Did doctors talk in front of you as if you weren’t there?</td>
<td>-</td>
</tr>
<tr>
<td>C6</td>
<td></td>
<td>If you ever needed to talk to a doctor, did you get the opportunity to do so?</td>
<td>4</td>
</tr>
<tr>
<td>C7</td>
<td></td>
<td>How would you rate the courtesy of your doctors?</td>
<td>-</td>
</tr>
<tr>
<td>C8</td>
<td></td>
<td>Did you ever think that doctors were deliberately not telling you certain things that you wanted to know?</td>
<td>-</td>
</tr>
<tr>
<td>C9</td>
<td></td>
<td>While you were in hospital, did doctors give you any information in a way which upset you?</td>
<td>-</td>
</tr>
<tr>
<td>C10</td>
<td></td>
<td>In your opinion, did the doctors who treated you know enough about your condition or treatment?</td>
<td>5</td>
</tr>
<tr>
<td>Q29</td>
<td>C11</td>
<td>As far as you know, did doctors wash or clean their hands between touching patients?</td>
<td>4</td>
</tr>
<tr>
<td>Q30</td>
<td>D1</td>
<td>When you had important questions to ask a nurse, did you get answers that you could understand?</td>
<td>4</td>
</tr>
<tr>
<td>D2</td>
<td></td>
<td>If you had any worries or fears about your condition or treatment, did a nurse discuss them with you?</td>
<td>4</td>
</tr>
<tr>
<td>Q31</td>
<td>D3</td>
<td>Did you have confidence and trust in the nurses treating you?</td>
<td>-</td>
</tr>
<tr>
<td>Q32</td>
<td>D4</td>
<td>Did nurses talk in front of you as if you weren’t there?</td>
<td>-</td>
</tr>
<tr>
<td>D5</td>
<td></td>
<td>While you were in hospital, did nurses ever give you any information in a way which upset you?</td>
<td>-</td>
</tr>
<tr>
<td>Q33</td>
<td>D6</td>
<td>In your opinion, were there enough nurses on duty to care for you in hospital?</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>D7</td>
<td>If you ever needed to talk to a nurse, did you get the opportunity to do so?</td>
<td>4</td>
</tr>
<tr>
<td>D8</td>
<td></td>
<td>How would you rate the courtesy of your nurses?</td>
<td>-</td>
</tr>
<tr>
<td>D9</td>
<td></td>
<td>Did you ever think that nurses were deliberately not telling you certain things that you wanted to know?</td>
<td>-</td>
</tr>
<tr>
<td>D10</td>
<td></td>
<td>In your opinion, did the nurses who treated you know enough about your condition or treatment?</td>
<td>5</td>
</tr>
<tr>
<td>Q34</td>
<td>D11</td>
<td>As far as you know, did nurses wash or clean their hands between touching patients?</td>
<td>4</td>
</tr>
<tr>
<td>Q35</td>
<td>E1</td>
<td>Sometimes in a hospital, a member of staff will say one thing and another will say something quite different. Did this happen to you?</td>
<td>-</td>
</tr>
<tr>
<td>Q36</td>
<td>E2</td>
<td>Were you involved as much as you wanted to be in decisions about your care and treatment?</td>
<td>-</td>
</tr>
<tr>
<td>Q37</td>
<td>E3</td>
<td>How much information about your condition or treatment was given to you?</td>
<td>-</td>
</tr>
<tr>
<td>Q38</td>
<td>E4</td>
<td>If your family or someone else close to you wanted to talk to a doctor, did they have enough opportunity to do so?</td>
<td>4, 5, 6</td>
</tr>
<tr>
<td>E5</td>
<td></td>
<td>How much information about your condition or treatment was given to your family or someone close to you?</td>
<td>4, 5, 6</td>
</tr>
<tr>
<td>Q39</td>
<td>E6</td>
<td>Did you find someone on the hospital staff to talk to about your worries and fears?</td>
<td>4</td>
</tr>
<tr>
<td>Q40</td>
<td>E7</td>
<td>Were you given enough privacy when discussing your condition or treatment?</td>
<td>-</td>
</tr>
<tr>
<td>Q41</td>
<td>E8</td>
<td>Were you given enough privacy when being examined or treated?</td>
<td>-</td>
</tr>
<tr>
<td>CORE</td>
<td>BANK</td>
<td>Question</td>
<td>Non-specific responses</td>
</tr>
<tr>
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<td>------------------------</td>
</tr>
<tr>
<td>E9</td>
<td>Q42</td>
<td>When you needed help from staff getting to the bathroom or toilet, did you get it in time?</td>
<td>4</td>
</tr>
<tr>
<td>E10</td>
<td>Q43</td>
<td>Did you get enough help from staff to eat your meals?</td>
<td>4</td>
</tr>
<tr>
<td>E11</td>
<td></td>
<td>How many minutes after you used the call button did it usually take before you got the help you needed?</td>
<td>6</td>
</tr>
<tr>
<td>E12</td>
<td></td>
<td>During your stay in hospital, did doctors, nurses, or other hospital staff ask you your name and address more often than you thought should have been necessary?</td>
<td>-</td>
</tr>
<tr>
<td>E13</td>
<td></td>
<td>During your stay in hospital, did doctors, nurses, or other hospital staff ask you to give details of your condition or illness more often than you thought should have been necessary?</td>
<td>-</td>
</tr>
<tr>
<td>E14</td>
<td></td>
<td>During your stay in hospital, did you have any tests, x-rays, or scans other than blood or urine tests?</td>
<td>-</td>
</tr>
<tr>
<td>E15</td>
<td></td>
<td>Were you told in advance when your tests, x-rays, or scans were going to take place?</td>
<td>-</td>
</tr>
<tr>
<td>E16</td>
<td></td>
<td>Were your scheduled tests, x-rays or scans performed on time?</td>
<td>-</td>
</tr>
<tr>
<td>E17</td>
<td></td>
<td>Did a member of staff explain why the scheduled tests were not performed on time?</td>
<td>-</td>
</tr>
<tr>
<td>E18</td>
<td></td>
<td>Did a doctor or nurse explain the results of the test in a way that you could understand?</td>
<td>-</td>
</tr>
<tr>
<td>E19</td>
<td></td>
<td>Were medical students present when you were being examined or treated?</td>
<td>-</td>
</tr>
<tr>
<td>E20</td>
<td></td>
<td>Were you asked for permission for medical students to be present when you were being treated or examined?</td>
<td>-</td>
</tr>
<tr>
<td>E21</td>
<td></td>
<td>Were you upset because medical students were present?</td>
<td>-</td>
</tr>
<tr>
<td>F1</td>
<td>Q44</td>
<td>Were you ever in any pain?</td>
<td>-</td>
</tr>
<tr>
<td>F2</td>
<td></td>
<td>When you had pain, was it usually severe, moderate, or mild?</td>
<td>-</td>
</tr>
<tr>
<td>F3</td>
<td></td>
<td>During your stay in hospital, how much of the time were you in pain?</td>
<td>-</td>
</tr>
<tr>
<td>F4</td>
<td></td>
<td>Did you ever request pain medicine?</td>
<td>-</td>
</tr>
<tr>
<td>F5</td>
<td></td>
<td>How many minutes after you requested pain medicine did it usually take before you got it?</td>
<td>-</td>
</tr>
<tr>
<td>F6</td>
<td></td>
<td>While you were in hospital, were you given any medicine to help with your pain (such as tablets, a spray, or pump) which you could decide when to take without having to ask hospital staff?</td>
<td>-</td>
</tr>
<tr>
<td>F7</td>
<td>Q45</td>
<td>Do you think the hospital staff did everything they could to help control your pain?</td>
<td>-</td>
</tr>
<tr>
<td>F8</td>
<td></td>
<td>Overall, how much pain medication did you get?</td>
<td>-</td>
</tr>
<tr>
<td>G1</td>
<td>Q46</td>
<td>During your stay in hospital, did you have an operation or procedure?</td>
<td>-</td>
</tr>
<tr>
<td>G2</td>
<td></td>
<td>Beforehand, did a member of staff explain the risks and benefits of the operation or procedure in a way you could understand?</td>
<td>4</td>
</tr>
<tr>
<td>G3</td>
<td></td>
<td>Beforehand, did a member of staff explain what would be done during the operation or procedure?</td>
<td>4</td>
</tr>
<tr>
<td>G4</td>
<td></td>
<td>Beforehand, did a member of staff explain your questions about the operation or procedure in a way you could understand?</td>
<td>4</td>
</tr>
<tr>
<td>G5</td>
<td></td>
<td>Beforehand, were you told how you could expect to feel after you had the operation or procedure?</td>
<td>-</td>
</tr>
<tr>
<td>G6</td>
<td>Q51</td>
<td>Before the operation or procedure, were you given an anaesthetic to put you to sleep or control your pain?</td>
<td>-</td>
</tr>
<tr>
<td>CORE</td>
<td>BANK</td>
<td>Question</td>
<td>Non-specific responses</td>
</tr>
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<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>------------------------</td>
</tr>
<tr>
<td>Q52</td>
<td>G7</td>
<td>Before the operation or procedure, did the anaesthetist explain how he or she would put you to sleep or control your pain in a way you could understand?</td>
<td>-</td>
</tr>
<tr>
<td>Q53</td>
<td>G8</td>
<td>After the operation or procedure, did a member of staff explain how the operation or procedure had gone in a way you could understand?</td>
<td>-</td>
</tr>
<tr>
<td>H1</td>
<td></td>
<td>Do you feel you were discharged too early, at the right time, or too late?</td>
<td>-</td>
</tr>
<tr>
<td>Q54</td>
<td>H2</td>
<td>On the day you left hospital, was your discharge delayed for any reason?</td>
<td>-</td>
</tr>
<tr>
<td>Q55</td>
<td>H3</td>
<td>What was the main reason for the delay?</td>
<td>-</td>
</tr>
<tr>
<td>Q56</td>
<td>H4</td>
<td>How long was the delay?</td>
<td>-</td>
</tr>
<tr>
<td>H5</td>
<td></td>
<td>Before you left hospital, did the doctors and nurses spend enough time telling you about what would happen during your recovery at home?</td>
<td>-</td>
</tr>
<tr>
<td>H6</td>
<td></td>
<td>Before you left hospital, were you given any written or printed information about what you should or should not do during your recovery after leaving hospital?</td>
<td>-</td>
</tr>
<tr>
<td>Q57</td>
<td>H7</td>
<td>Did a member of staff explain the purpose of the medicines you were to take at home in a way you could understand?</td>
<td>4, 5</td>
</tr>
<tr>
<td>Q58</td>
<td>H8</td>
<td>Did a member of staff tell you about medication side effects to watch for when you went home?</td>
<td>4</td>
</tr>
<tr>
<td>Q59</td>
<td>H9</td>
<td>Were you given clear written information about your medicines?</td>
<td>4</td>
</tr>
<tr>
<td>Q60</td>
<td>H10</td>
<td>Did a member of staff tell you about any danger signals you should watch for after you went home?</td>
<td>4</td>
</tr>
<tr>
<td>H11</td>
<td></td>
<td>Did hospital staff take your family or home situation into account when planning your discharge?</td>
<td>-</td>
</tr>
<tr>
<td>Q61</td>
<td>H12</td>
<td>Did the doctors or nurses give your family or someone close to you all the information they needed to help you recover?</td>
<td>4, 5</td>
</tr>
<tr>
<td>H13</td>
<td></td>
<td>Did someone tell you when you could resume your usual activities, such as when to go back to work or drive a car?</td>
<td>-</td>
</tr>
<tr>
<td>Q62</td>
<td>H14</td>
<td>Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?</td>
<td>3</td>
</tr>
<tr>
<td>H15</td>
<td></td>
<td>Did hospital staff discuss with you whether you would need any health or social care services after leaving hospital? (e.g. district nurse, care assistant, physiotherapist or social worker)</td>
<td>3</td>
</tr>
<tr>
<td>Q63</td>
<td>H16</td>
<td>Did you receive copies of letters sent between hospital doctors and your family doctor (GP)?</td>
<td>3</td>
</tr>
<tr>
<td>J1</td>
<td></td>
<td>Did you know that you could ask to look at the file of your medical records while you were in hospital?</td>
<td>-</td>
</tr>
<tr>
<td>J2</td>
<td></td>
<td>While you were in hospital, did you look at the file of your medical records?</td>
<td>3</td>
</tr>
<tr>
<td>Q64</td>
<td>K1</td>
<td>Overall, did you feel you were treated with respect and dignity while you were in the hospital?</td>
<td>-</td>
</tr>
<tr>
<td>Q65</td>
<td>K2</td>
<td>How would you rate how well the doctors and nurses worked together?</td>
<td>-</td>
</tr>
<tr>
<td>Q66</td>
<td>K3</td>
<td>Overall, how would you rate the care you received?</td>
<td>-</td>
</tr>
<tr>
<td>K4</td>
<td></td>
<td>Would you recommend this hospital to your family and friends?</td>
<td>-</td>
</tr>
<tr>
<td>Q67</td>
<td>K5</td>
<td>During your hospital stay, were you ever asked to give your views on the quality of your care?</td>
<td>3</td>
</tr>
<tr>
<td>Q68</td>
<td>K6</td>
<td>Were you given information about how you could complain about the hospital care you received?</td>
<td>-</td>
</tr>
<tr>
<td>Q69</td>
<td>L1</td>
<td>Are you male or female?</td>
<td>-</td>
</tr>
<tr>
<td>CORE</td>
<td>BANK</td>
<td>Question</td>
<td>Non-specific responses</td>
</tr>
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<td>------------------------</td>
</tr>
<tr>
<td>Q70</td>
<td>L2</td>
<td>What was your year of birth?</td>
<td>-</td>
</tr>
<tr>
<td>Q71</td>
<td>L3</td>
<td>How old were you when you left full-time education?</td>
<td>-</td>
</tr>
<tr>
<td>Q72</td>
<td>L4</td>
<td>Overall, how would you rate your health during the past 4 weeks?</td>
<td>-</td>
</tr>
<tr>
<td>Q73</td>
<td>L5</td>
<td>Do you have a long-standing physical or mental health problem or disability?</td>
<td>-</td>
</tr>
<tr>
<td>Q74</td>
<td>L6</td>
<td>Does this problem or disability affect your day-to-day activities?</td>
<td>-</td>
</tr>
<tr>
<td>Q75</td>
<td>L7</td>
<td>To which of these ethnic groups would you say you belong? (Tick ONE only)</td>
<td>-</td>
</tr>
</tbody>
</table>
6 Submitting data

Data may be submitted to the Acute Co-ordination Centre either by e-mail or by post (with the data on a CD or floppy disk). There is no requirement for the anonymised dataset to be password protected. Data should be submitted to the following address:

By e-mail: Acute.Data@PickerEurope.ac.uk
or
By post: Acute Co-ordination Centre – Inpatient Survey 2006
Picker Institute Europe
King’s Mead House
Oxpens Road
Oxford
OX1 1RX
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1. Introduction

This document outlines the method used by the Healthcare Commission to group and score the performance indicator questions included within the 2006 inpatient survey, carried out by acute and specialist trusts in autumn 2006.

It also details the methodology used to calculate the overall scores for each individual trust, in terms of the five domains of patient experience used by the Department of Health (see Figure 1).

Figure 1: Domains of patient experience

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<td>• Access and waiting</td>
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<tr>
<td>• Safe, high quality, coordinated care</td>
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<td>• Better information, more choice</td>
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<td>• Building relationships</td>
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<td>• Clean, comfortable, friendly place to be</td>
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2. Domains: Selected indicator questions

The 2006 inpatient survey consisted of 75 pre-coded questions, and three open-ended questions designed to collect written comments and feedback. Of these, 60 questions were classified as being potential evaluative questions, and were allocated to one of the Department of Health’s five domains on the experiences of patients.

The criteria listed in Figure 2 were used to assess the suitability of each individual question, in terms of its viability as an indicator of performance. Using these criteria, 20 of the questions were then selected to be used in the calculation of the performance indicators. See Appendix A for the questions included within each domain.
Figure 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 performance indicators.

- Numbers of questions in each domain
  There should be between 2 and 6 questions in each domain for each survey.

- 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 were scored using a scale of 0 to 100. A listing of scores assigned to the responses to each individual question is provided in Appendix B.

The scores represent the extent to which the patient’s experience could be improved. A score of 0 was assigned to all responses that reflect considerable scope for improvement, whereas a response that was assigned a score of 100 referred to a positive patient experience. Where options were provided that did not have any bearing on the trust’s performance in terms of patient experience, the responses were classified as “not applicable” and a score was not given. For example, where respondents stated they could not remember or did not know the answer to a question, a score was not given.

For example, question 26 in the inpatient survey (Figure 3.1) asks whether the respondent could understand the doctor’s answers to important questions. The
option of “No” was allocated a score of 0, as this suggests that the experiences of the patient need to be improved. A score of 100 was assigned to the option “Yes, always” as it reflects a positive patient experience. The remaining option, “sometimes”, was assigned a score of 50 as the patient sometimes understood the doctor’s answer, although not consistently. Hence it was placed on the midpoint of the scale.

If the patient had no need to ask questions, this was classified as a “not applicable” response, as this option was not a direct measure of whether or not the doctor gave answers that the patient could understand.

Figure 3.1 Scoring example: Question 26 (2006 Inpatient Survey)

<table>
<thead>
<tr>
<th>Q26. When you had important questions to ask a doctor, did you get answers that you could understand?</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes, always</td>
<td>100</td>
</tr>
<tr>
<td>Yes, sometimes</td>
<td>50</td>
</tr>
<tr>
<td>No</td>
<td>0</td>
</tr>
<tr>
<td>I had no need to ask</td>
<td>Not applicable</td>
</tr>
</tbody>
</table>

Where a number of options lay between the negative and positive responses, they were placed in appropriate positions along the scale. For example, question 13 asks whether the hospital changed the admission date (Figure 3.2). The following response options were provided:

- No
- Yes, once
- Yes, 2 or 3 times
- Yes, 4 times or more

A score of 100 was assigned to the option ‘No’ (the hospital did not change the admission date), as this represents best practice in terms of patient experience. A response that the date was changed four times or more was given a score of 0. The remaining two answers were assigned a score that reflected their position in terms of best practice, spread evenly across the scale. Hence the option ‘Yes, once’ was assigned a score of 67, ‘Yes, two or more times’ was given a score of 33.

Figure 3.2 Scoring example: Question 16 (2006 Inpatient Survey)

16. Was your admission date changed by the hospital?

<table>
<thead>
<tr>
<th>16. Was your admission date changed by the hospital?</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>100</td>
</tr>
<tr>
<td>Yes, once</td>
<td>67</td>
</tr>
<tr>
<td>Yes, 2 or 3 times</td>
<td>33</td>
</tr>
<tr>
<td>Yes, 4 times or more</td>
<td>0</td>
</tr>
</tbody>
</table>
4. Methodology: Overall domain scores

The scores for each domain in each trust were calculated using the method described in sections 4.1 to 4.4 below.

Weights were calculated to adjust for any variation between trusts that resulted from differences in the age, sex and method of admission of patients. A weight was calculated for each respondent by dividing the national proportion of respondents in their age/sex/admission method group by the corresponding trust proportion. As shown in section 4.4, the final domain score was calculated by first dividing the sum of weighted scores for all eligible responses by the weighted number of eligible respondents for each question that contributed to a domain. The mean of these ‘question means’ was then taken as the trust score.

The reason for weighting the data was that younger people, women and those who were admitted as emergencies tend to be more critical in their responses than older people, men and elective patients. If a trust had a large population of young people, women or emergency patients, their performance might be judged more harshly than if there was a more consistent distribution of age, sex and method of admission.

4.1 Weighted analysis

The first stage of the analysis involved calculating national age/sex/admission method proportions. It must be noted that the term “national proportion” is used loosely here as it was obtained from pooling the survey data from all trusts, and was therefore based on the respondent population rather than the entire population of England.

The questionnaire asked respondents to state their year of birth. The approximate age of each patient was then calculated by subtracting the figure given from 2006. The respondents were then grouped according to the categories shown in Figure 4.1.1.

If a patient did not fill in their year of birth or sex on the questionnaire, this information was inputted from the sample file. If information on a respondent’s age and/or sex was missing from both the questionnaire and the sample file, the patient was excluded from the analysis.

Question 1 asked “Was your most recent hospital stay planned in advance or an emergency?”. Respondents that ticked “emergency or urgent” were classed as emergency patients for the purpose of the weightings. Those that ticked “waiting list or planned in advance” were classed as elective patients. However, if respondents ticked “something else” or did not answer question 1, information was taken from other responses to the questionnaire to determine the method of admission.

Emergency admission:

- If the respondent answered "emergency or urgent" at question 1.
- Or
  - If the respondent answered “something else” or did not respond to question 1, and answered ‘yes’ to question 2.
- Or
  - If the respondent answered “something else” or did not respond to question 1, did not answer question 2, but responded to one or more of questions 3, 4 and 5.
Or
➢ If the respondent answered “something else” or did not respond to question 1, and answered ‘yes’ to question 6.

Or
➢ If the respondent answered “something else” or did not respond to question 1, did not answer question 6, but responded to one or more of questions 7, 8 and 9.

Elective admission:
➢ If the respondent answered "waiting list or planned in advance" at question 1.

Or
➢ If the respondent answered “something else” or did not respond to question 1, did not answer questions 2, 3, 4, 5, 6, 7, 8 and 9, and gave at least one response to questions 10, 11, 12 and 13.

All other combinations of responses for questions 1 to 13 resulted in the respondent being excluded from the analysis, as it was not possible to determine admission method.

The national age/ sex/ admission method proportions relate to the proportion of men, and women who were admitted as emergencies/ electives within each age group. As shown in Figure 4.1.1, the proportion of men who were admitted as emergencies aged 51-65 years is 0.068, the proportion of women who admitted as emergencies aged 51-65 years is 0.060, etc.

Figure 4.1.1 National Proportions (inpatients)

<table>
<thead>
<tr>
<th>Sex</th>
<th>Admission Method</th>
<th>Age Group</th>
<th>National Proportion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Men</td>
<td>Emergency</td>
<td>≤35</td>
<td>0.022</td>
</tr>
<tr>
<td></td>
<td></td>
<td>36-50</td>
<td>0.038</td>
</tr>
<tr>
<td></td>
<td></td>
<td>51-65</td>
<td><strong>0.068</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>66+</td>
<td>0.134</td>
</tr>
<tr>
<td>Women</td>
<td>Emergency</td>
<td>≤35</td>
<td>0.039</td>
</tr>
<tr>
<td></td>
<td></td>
<td>36-50</td>
<td>0.045</td>
</tr>
<tr>
<td></td>
<td></td>
<td>51-65</td>
<td><strong>0.060</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>66+</td>
<td>0.149</td>
</tr>
<tr>
<td>Men</td>
<td>Elective</td>
<td>≤35</td>
<td>0.013</td>
</tr>
<tr>
<td></td>
<td></td>
<td>36-50</td>
<td>0.024</td>
</tr>
<tr>
<td></td>
<td></td>
<td>51-65</td>
<td>0.058</td>
</tr>
<tr>
<td></td>
<td></td>
<td>66+</td>
<td>0.099</td>
</tr>
<tr>
<td>Women</td>
<td>Elective</td>
<td>≤35</td>
<td>0.025</td>
</tr>
<tr>
<td></td>
<td></td>
<td>36-50</td>
<td>0.052</td>
</tr>
<tr>
<td></td>
<td></td>
<td>51-65</td>
<td>0.077</td>
</tr>
<tr>
<td></td>
<td></td>
<td>66+</td>
<td>0.097</td>
</tr>
</tbody>
</table>

Note: All proportions are given to three decimals places for this example. The analysis included these figures to nine decimal places.

These proportions were calculated for each trust, using the same procedure.

The next step was to calculate the weighting for each individual. Age/ sex/ admission method weightings were calculated for each respondent by dividing the national proportion of respondents in their age/ sex/ admission method group by the corresponding trust proportion.
If, for example, a lower proportion of men who were admitted as emergencies aged between 51 and 65 years within Trust A responded to the survey, in comparison with the national proportion, then this group would be under-represented in the final scores. Dividing the national proportion by the trust proportion results in a greater weighting for members of this group (Figure 4.1.2). This increases the influence of responses made by respondents within that group in the final score, thus counteracting the low representation.

**Figure 4.1.2 Proportion and Weighting for Trust A**

<table>
<thead>
<tr>
<th>Sex</th>
<th>Admission</th>
<th>Age Group</th>
<th>National Proportion</th>
<th>Trust A Proportion</th>
<th>Trust A Weight (National/Trust A)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Men</td>
<td>Emergency</td>
<td>≤35</td>
<td>0.022</td>
<td>0.018</td>
<td>1.222</td>
</tr>
<tr>
<td></td>
<td></td>
<td>36-50</td>
<td>0.038</td>
<td>0.035</td>
<td>1.086</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>51-65</strong></td>
<td><strong>0.068</strong></td>
<td><strong>0.047</strong></td>
<td><strong>1.447</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>66+</td>
<td>0.134</td>
<td>0.095</td>
<td>1.411</td>
</tr>
<tr>
<td>Women</td>
<td>Emergency</td>
<td>≤35</td>
<td>0.039</td>
<td>0.045</td>
<td>0.867</td>
</tr>
<tr>
<td></td>
<td></td>
<td>36-50</td>
<td>0.045</td>
<td>0.057</td>
<td>0.789</td>
</tr>
<tr>
<td></td>
<td></td>
<td>51-65</td>
<td>0.060</td>
<td>0.085</td>
<td>0.706</td>
</tr>
<tr>
<td></td>
<td></td>
<td>66+</td>
<td>0.149</td>
<td>0.117</td>
<td>1.274</td>
</tr>
<tr>
<td>Men</td>
<td>Elective</td>
<td>≤35</td>
<td>0.013</td>
<td>0.018</td>
<td>0.722</td>
</tr>
<tr>
<td></td>
<td></td>
<td>36-50</td>
<td>0.024</td>
<td>0.035</td>
<td>0.686</td>
</tr>
<tr>
<td></td>
<td></td>
<td>51-65</td>
<td>0.058</td>
<td>0.047</td>
<td>1.234</td>
</tr>
<tr>
<td></td>
<td></td>
<td>66+</td>
<td>0.099</td>
<td>0.095</td>
<td>1.042</td>
</tr>
<tr>
<td>Women</td>
<td>Elective</td>
<td>≤35</td>
<td>0.025</td>
<td>0.045</td>
<td>0.556</td>
</tr>
<tr>
<td></td>
<td></td>
<td>36-50</td>
<td>0.052</td>
<td>0.057</td>
<td>0.912</td>
</tr>
<tr>
<td></td>
<td></td>
<td>51-65</td>
<td>0.077</td>
<td>0.085</td>
<td>0.906</td>
</tr>
<tr>
<td></td>
<td></td>
<td>66+</td>
<td>0.097</td>
<td>0.119</td>
<td>0.815</td>
</tr>
</tbody>
</table>

Note: All proportions are given to three decimals places for this example. The analysis included these figures to nine decimal places

Likewise, if a considerably higher proportion of women who were admitted as emergencies aged between 36 and 50 from Trust B responded to the survey (Figure 4.1.3), then this group would be over-represented within the sample, compared with national representation of this group. Subsequently this group would have a greater influence over the final score. To counteract this, dividing the national proportion by the proportion for Trust B results in a lower weighting of this group.

**Figure 4.1.3 Proportion and Weighting for Trust B**

<table>
<thead>
<tr>
<th>Sex</th>
<th>Admission</th>
<th>Age Group</th>
<th>National Proportion</th>
<th>Trust B Proportion</th>
<th>Trust B Weight (National/Trust B)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Men</td>
<td>Emergency</td>
<td>≤35</td>
<td>0.022</td>
<td>0.016</td>
<td>1.375</td>
</tr>
<tr>
<td></td>
<td></td>
<td>36-50</td>
<td>0.038</td>
<td>0.029</td>
<td>1.310</td>
</tr>
<tr>
<td></td>
<td></td>
<td>51-65</td>
<td>0.068</td>
<td>0.062</td>
<td>1.097</td>
</tr>
<tr>
<td></td>
<td></td>
<td>66+</td>
<td>0.134</td>
<td>0.091</td>
<td>1.473</td>
</tr>
<tr>
<td>Women</td>
<td>Emergency</td>
<td>≤35</td>
<td>0.039</td>
<td>0.034</td>
<td>1.147</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>36-50</strong></td>
<td><strong>0.045</strong></td>
<td><strong>0.075</strong></td>
<td><strong>0.600</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>51-65</td>
<td>0.060</td>
<td>0.080</td>
<td>0.750</td>
</tr>
<tr>
<td></td>
<td></td>
<td>66+</td>
<td>0.149</td>
<td>0.110</td>
<td>1.355</td>
</tr>
<tr>
<td>Men</td>
<td>Elective</td>
<td>≤35</td>
<td>0.013</td>
<td>0.016</td>
<td>0.813</td>
</tr>
<tr>
<td></td>
<td></td>
<td>36-50</td>
<td>0.024</td>
<td>0.029</td>
<td>0.828</td>
</tr>
<tr>
<td></td>
<td></td>
<td>51-65</td>
<td>0.058</td>
<td>0.062</td>
<td>0.935</td>
</tr>
</tbody>
</table>
4.2 Obtaining the numerators for each domain score

The responses given by each respondent were entered into a dataset using the 0-100 scale described in section 3. Each row corresponded to an individual respondent, and each column related to a performance indicator question. For those questions that the respondent did not answer (or received a “not applicable” score for), the relevant cell remained empty. Alongside these were the weightings allocated to each respondent (Figure 4.2.1).

Figure 4.2.1 Scoring for “Building relationships” domain, Trust B (Inpatients)

<table>
<thead>
<tr>
<th>Respondent</th>
<th>26</th>
<th>28</th>
<th>30</th>
<th>32</th>
<th>Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>100</td>
<td>50</td>
<td>50</td>
<td>100</td>
<td>1.375</td>
</tr>
<tr>
<td>2</td>
<td>50</td>
<td>100</td>
<td>100</td>
<td></td>
<td>1.021</td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
<td>50</td>
<td>100</td>
<td>0.735</td>
</tr>
</tbody>
</table>

Respondents’ scores for each question were then multiplied individually by the relevant weighting, in order to obtain the numerators for the domain scores (Figure 4.2.2).

Figure 4.2.2 Numerators for “Building relationships” domain, Trust B (Inpatients)

<table>
<thead>
<tr>
<th>Respondent</th>
<th>Numerators:</th>
<th>Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>137.5</td>
<td>1.375</td>
</tr>
<tr>
<td>2</td>
<td>51.05</td>
<td>1.021</td>
</tr>
<tr>
<td>3</td>
<td>.</td>
<td>0.735</td>
</tr>
</tbody>
</table>

4.3 Obtaining the denominators for each domain score

A second dataset was then created. This contained a column for each question, grouped into domains, and again with each row corresponding to an individual respondent. A value of one was entered for the questions where a response had been given by the respondent, and all questions that had been left unanswered or allocated a scoring of “not applicable” (section 3) were set to missing (Figure 4.3.1).
Figure 4.3.1 Values for non-missing responses, “Building relationships” domain, Trust B (Inpatients)

<table>
<thead>
<tr>
<th>Respondent</th>
<th>Responded to question</th>
<th>Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>26 28 30 32</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>1 1 1 1</td>
<td>1.375</td>
</tr>
<tr>
<td>2</td>
<td>1 1 1 .</td>
<td>1.021</td>
</tr>
<tr>
<td>3</td>
<td>. . 1 1</td>
<td>0.735</td>
</tr>
</tbody>
</table>

The denominators were calculated by multiplying each of the cells within the second dataset by the weighting allocated to each respondent. This resulted in a figure for each question that the respondent had answered (Figure 4.3.2). Again, the cells relating to the questions that the respondent did not answer (or received a “not applicable” score for) remained set to missing.

Figure 4.3.2 Denominators for “Building relationships” domain, Trust B (Inpatients)

<table>
<thead>
<tr>
<th>Respondent</th>
<th>Denominators:</th>
<th>Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>26 28 30 32</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>1.375 1.375 1.375 1.375</td>
<td>1.375</td>
</tr>
<tr>
<td>2</td>
<td>1.021 1.021 1.021 .</td>
<td>1.021</td>
</tr>
<tr>
<td>3</td>
<td>. . 0.735 0.735</td>
<td>0.735</td>
</tr>
</tbody>
</table>

4.4 Final calculation

The final score for each domain was calculated using a two-step process. Firstly, weighted mean scores were calculated for each of the questions that contribute to the domain, by dividing the sum of the weighted scores for a question (i.e. numerators), by the weighted sum of all eligible respondents to the question (i.e. denominators) for each trust. A simple mean of each of these question means was then taken to give the final trust domain score.

Using the example data for trust B, we first calculated weighted mean scores for each of the four questions that contributed to the ‘building relationships’ domain.

- **Q26:** \[\frac{137.50 + 51.05}{1.375 + 1.021} = 78.694\]
- **Q28:** \[\frac{68.750 + 102.100}{1.375 + 1.021} = 71.306\]
- **Q30:** \[\frac{68.750 + 102.100 + 36.750}{1.375 + 1.021 + 0.735} = 66.305\]
- **Q32:** \[\frac{137.500 + 73.500}{1.375 + 0.735} = 100.000\]

The final domain score is the mean of these four values:

\[78.694 + 71.306 + 66.305 + 100.000 = 79.706\]

This process was repeated for each of the domains.
Standard errors were calculated for each domain score using a standard bootstrapping technique (Effron, B. & Tibshirani, J. (1998) *An Introduction to the Bootstrap* Chapman & Hall / CRC, London)

4.5 *Statistical techniques used in the patient survey performance indicators* - Calculation of the $Z_D$ scores

Patient survey indicators in the 2006/07 annual health check were banded using a slightly modified version of the methodology as that used in the 2003/04 and 2004/05 star ratings. This method was based on a process of standardisation where a $Z_D$ score was calculated for each trust which related to the difference between the trust score, and the national mean score of all trusts. For 2006/07, the $Z_D$ scores are calculated for a combined overall domain score, which combines the five distinct domains into one overall score, and uses the pooled variance of the five scores.

More technical details on the calculation of the $Z_D$ score can be found in Appendix C. In summary, the $Z_D$ score for a trust was calculated as the trust score minus the national mean score, divided by the standard error of the trust score plus the variance of the scores between trusts. This method of calculating a $Z_D$ score differs from the standard method of calculating a $Z$ score in that it recognizes that there is likely to be natural variation between trusts which one should expect, and accept. Rather than comparing each trusts to one point only (i.e. the national mean score), it compares each trust to a distribution of acceptable scores. This is achieved by adding some of the variance of the scores between trusts to the denominator.
Appendix A:

2006 Inpatient survey - performance indicator questions, grouped within each domain

### Access and Waiting

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

13. Was your admission date changed by the hospital? [waiting list only]

14. 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? [All types of admission]

### Safe, high quality, coordinated care

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

56. 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 q55 – see Appendix B for details)

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

### Better information, more choice

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

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

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

### Building relationships

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

28. Did doctors talk in front of you as if you weren’t there?

30. When you had important questions to ask a nurse, did you get answers that you could understand?
<table>
<thead>
<tr>
<th>Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>32. Did nurses talk in front of you as if you weren’t there?</td>
</tr>
</tbody>
</table>

### Clean, comfortable, friendly place to be

<table>
<thead>
<tr>
<th>Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>20. Were you bothered by noise at night from other patients?</td>
</tr>
<tr>
<td>21. Were you bothered by noise at night from hospital staff?</td>
</tr>
<tr>
<td>22. In your opinion, how clean was the hospital room or ward that you were in?</td>
</tr>
<tr>
<td>24. How would you rate the hospital food?</td>
</tr>
<tr>
<td>41. Were you given enough privacy when being examined or treated?</td>
</tr>
<tr>
<td>45. Do you think the hospital staff did everything they could to help control your pain?</td>
</tr>
<tr>
<td>64. Overall, did you feel you were treated with respect and dignity while you were in the hospital?</td>
</tr>
</tbody>
</table>
### Appendix B

#### 2006 Inpatient survey - scoring of individual indicator questions

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

<table>
<thead>
<tr>
<th>Response</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>I was admitted as soon as I thought was necessary</td>
<td>100</td>
</tr>
<tr>
<td>I should have been admitted a bit sooner</td>
<td>50</td>
</tr>
<tr>
<td>I should have been admitted a lot sooner</td>
<td>0</td>
</tr>
</tbody>
</table>

13. **Was your admission date changed by the hospital?**

<table>
<thead>
<tr>
<th>Response</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>100</td>
</tr>
<tr>
<td>Yes, once</td>
<td>67</td>
</tr>
<tr>
<td>Yes, 2 or 3 times</td>
<td>33</td>
</tr>
<tr>
<td>Yes, 4 times or more</td>
<td>0</td>
</tr>
</tbody>
</table>

14. **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?**

<table>
<thead>
<tr>
<th>Response</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes, definitely</td>
<td>0</td>
</tr>
<tr>
<td>Yes, to some extent</td>
<td>50</td>
</tr>
<tr>
<td>No</td>
<td>100</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Response</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>0</td>
</tr>
<tr>
<td>No</td>
<td>100</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Response</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>0</td>
</tr>
<tr>
<td>No</td>
<td>100</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Response</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very clean</td>
<td>100</td>
</tr>
<tr>
<td>Fairly clean</td>
<td>67</td>
</tr>
<tr>
<td>Not very clean</td>
<td>33</td>
</tr>
<tr>
<td>Not at all clean</td>
<td>0</td>
</tr>
</tbody>
</table>

24. **How would you rate the hospital food?**

<table>
<thead>
<tr>
<th>Response</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very good</td>
<td>100</td>
</tr>
<tr>
<td>Good</td>
<td>67</td>
</tr>
<tr>
<td>Fair</td>
<td>33</td>
</tr>
<tr>
<td>Poor</td>
<td>0</td>
</tr>
<tr>
<td>I did not have any hospital food</td>
<td>Not applicable</td>
</tr>
</tbody>
</table>
26. When you had important questions to ask a doctor, did you get answers that you could understand?

<table>
<thead>
<tr>
<th>Option</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes, always</td>
<td>100</td>
</tr>
<tr>
<td>Yes, sometimes</td>
<td>50</td>
</tr>
<tr>
<td>No</td>
<td>0</td>
</tr>
<tr>
<td>I had no need to ask</td>
<td>Not applicable</td>
</tr>
</tbody>
</table>

28. Did doctors talk in front of you as if you weren’t there?

<table>
<thead>
<tr>
<th>Option</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes, often</td>
<td>0</td>
</tr>
<tr>
<td>Yes, sometimes</td>
<td>50</td>
</tr>
<tr>
<td>No</td>
<td>100</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Option</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes, always</td>
<td>100</td>
</tr>
<tr>
<td>Yes, sometimes</td>
<td>50</td>
</tr>
<tr>
<td>No</td>
<td>0</td>
</tr>
<tr>
<td>I had no need to ask</td>
<td>Not applicable</td>
</tr>
</tbody>
</table>

32. Did nurses talk in front of you as if you weren’t there?

<table>
<thead>
<tr>
<th>Option</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes, often</td>
<td>0</td>
</tr>
<tr>
<td>Yes, sometimes</td>
<td>50</td>
</tr>
<tr>
<td>No</td>
<td>100</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Option</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes, often</td>
<td>0</td>
</tr>
<tr>
<td>Yes, sometimes</td>
<td>50</td>
</tr>
<tr>
<td>No</td>
<td>100</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Option</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes, definitely</td>
<td>100</td>
</tr>
<tr>
<td>Yes, to some extent</td>
<td>50</td>
</tr>
<tr>
<td>No</td>
<td>0</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Option</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes, always</td>
<td>100</td>
</tr>
<tr>
<td>Yes, sometimes</td>
<td>50</td>
</tr>
<tr>
<td>No</td>
<td>0</td>
</tr>
</tbody>
</table>
45. Do you think the hospital staff did everything they could to help control your pain?

<table>
<thead>
<tr>
<th>Response</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes, definitely</td>
<td>100</td>
</tr>
<tr>
<td>Yes, to some extent</td>
<td>50</td>
</tr>
<tr>
<td>No</td>
<td>0</td>
</tr>
</tbody>
</table>

**Note:** Q56 was 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 q55). If a respondent stated that no delay was experienced (q54) a score of 100 was automatically given. The option of “something else” causing the delay in q55 was excluded from the analysis, as the exact cause could not be attributed to trust performance. If any option for Q56 is ticked, though the reason for the delay is not given (Q55 is not answered), a score is not given for the response to Q56.

56. How long was the delay [of your discharge on the day you left hospital]? (see note above)

<table>
<thead>
<tr>
<th>Duration</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Up to 1 hour</td>
<td>75</td>
</tr>
<tr>
<td>Longer than 1 hour but no longer than 2 hours</td>
<td>50</td>
</tr>
<tr>
<td>Longer than 2 hours but no longer than 4 hours</td>
<td>25</td>
</tr>
<tr>
<td>Longer than 4 hours</td>
<td>0</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Response</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes, completely</td>
<td>100</td>
</tr>
<tr>
<td>Yes, to some extent</td>
<td>50</td>
</tr>
<tr>
<td>No</td>
<td>0</td>
</tr>
<tr>
<td>I did not need an explanation</td>
<td>Not applicable</td>
</tr>
<tr>
<td>I had no medicines</td>
<td>Not applicable</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Response</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes, completely</td>
<td>100</td>
</tr>
<tr>
<td>Yes, to some extent</td>
<td>50</td>
</tr>
<tr>
<td>No</td>
<td>0</td>
</tr>
<tr>
<td>I did not need an explanation</td>
<td>Not applicable</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Response</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes, completely</td>
<td>100</td>
</tr>
<tr>
<td>Yes, to some extent</td>
<td>50</td>
</tr>
<tr>
<td>No</td>
<td>0</td>
</tr>
<tr>
<td>It was not necessary</td>
<td>Not applicable</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Response</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes, always</td>
<td>100</td>
</tr>
<tr>
<td>Yes, sometimes</td>
<td>50</td>
</tr>
<tr>
<td>No</td>
<td>0</td>
</tr>
</tbody>
</table>
Appendix C: Calculation of Z-statistics

Z statistics (or Z scores) are standardized scores derived from normally distributed data, where the value of the Z score translates directly to a p-value. That p-value then translates to what level of confidence you have in saying that a value is significantly different from the mean of your data (or your ‘target’ value).

For many of the indicators in the 2006/07 annual health check, the banding method has been based on the use of Z scores. Under this scheme, a trust with a Z score of < -3.1 is placed in band 1 (significantly below average; p<0.001 that the trust score is below the national average), -3.1 < Z < -1.96 in band 2 (below average; p<0.025 that the trust score is below the national average), -1.96 < Z < 1.96 in band 3 (average), 1.96 < Z < 3.1 in band 4 (above average; p<0.025 that the trust score is above the national average) and Z > 3.1 in band 5 (significantly above average; p<0.001 that the trust score is above the national average). A standard Z score is calculated as:

\[ z_i = \frac{y_i - \theta_0}{s_i} \]  

where \( s_i \) is the standard error of the trust mean score, \( y_i \) is the trust domain score, and \( \theta_0 \) is the national mean score (the target against which the trusts are being judged). However, for measures where there is a high level of precision (the survey indicators sample sizes average around 400 to 500 per trust) in the estimates, the standard Z score may give a disproportionately high number of trusts in the significantly above/ below average bands (because \( s_i \) is generally so small). This is compounded by the fact that all the factors that may affect a trust’s score cannot be controlled. For example, if trust scores are closely related to economic deprivation then there may be significant variation between trusts due to this factor, not necessarily due to factors within the trusts' control. In this situation, the data are said to be ‘over dispersed’. That problem can be partially overcome by the use of an ‘additive random effects model’ to calculate the Z score (we refer to this modified Z score as the ZD score). Under that model, we accept that there is natural variation between trust scores, and this variation is then taken into account by adding this to the trust’s local standard error in the denominator of (1). In effect, rather than comparing each trust simply to one national target value, we are comparing them to a national distribution.

The steps taken to calculate ZD scores are outlined below, but for a more detailed explanation please refer to the ‘explanation of statistical methods’ document in the ‘more information’ section of the 2006/2007 ratings website. Please note however that some of the formulae in this document differ from those in the methods document, because we are dealing with mean values rather than proportions or standardised rates.

Winsorising Z-scores

The first step when calculating ZD is to ‘winsorise’ the standard Z scores (from (1)). Winsorising consists of shrinking in the extreme Z-scores to some selected percentile, using the following method:

1. Rank cases according to their naive Z-scores.
2. Identify Zq and Z1-q, the 100q% most extreme top and bottom naive Z-scores, where q might, for example, be 0.1.
3. Set the lowest 100q% of Z-scores to Zq, and the highest 100q% of Z-scores to Z1-q. These are the Winsorised statistics.

This retains the same number of Z-scores but discounts the influence of outliers.

**Estimation of over-dispersion**

An over dispersion factor \( \hat{\phi} \) is estimated which allows us to say if the data are over dispersed or not:

\[
\hat{\phi} = \frac{1}{I} \sum_{i=1}^{I} z_i^2 \quad (2)
\]

where \( I \) is the sample size (number of trusts) and \( z_i \) is the Z score for the \( i \)th trust given by (1). The winsorised Z scores are used in estimating \( \hat{\phi} \). If \( \hat{\phi} < 1 + (2 \times \sqrt{2/I}) \) then the data are not over-dispersed, and we can simply use (1) to calculate standard Z scores.

**An additive random effects model**

If \( I \hat{\phi} \) is greater than \((I - 1)\) then we need to estimate the expected variance between trusts. We take this as the standard deviation of the distribution of \( \theta_i \) (trust means) for trusts, which are on target, we give this value the symbol \( \hat{\tau} \), which is estimated using the following formula:

\[
\hat{\tau}^2 = \frac{I\hat{\phi} - (I-1)}{\sum w_i - \sum w_i^2 / \sum w_i} \quad (3)
\]

where \( w_i = 1 / s_i^2 \) and \( \hat{\phi} \) is from (2). Once \( \hat{\tau} \) has been estimated, the ZD score is calculated as:

\[
Z_{iD} = \frac{Y_i - \theta_0}{\sqrt{S_i^2 + \hat{\tau}^2}} \quad (4)
\]

For a worked example using this method, please refer to the ‘explanation of statistical methods’ document in the ‘more information’ section of the 2006/07 ratings website. Please note however, that where in that \( s_i^0 \) is used, we simply use \( s_i \) for the data on surveys.
NHS patient survey programme

Survey of adult inpatients in the NHS 2006

The Healthcare Commission is the health watchdog. We exist to promote improvements in the quality of healthcare and public health in England and we are committed to making a real difference to the delivery of healthcare and to promoting continuous improvement for the benefit of patients and the public.

We have a statutory duty to assess the performance of healthcare organisations in the NHS and award annual ratings of performance, to coordinate inspections and reviews of healthcare organisations carried out by others, and register organisations providing healthcare in the independent sector.

Understanding what patients think about the care and treatment they receive is crucial to improving the quality of care being delivered by the NHS. One way of doing this is by asking patients who have recently used their local health services to tell us about their experiences.

This report contains the results of our fourth survey of adult inpatients in NHS trusts in England. It shows how each trust scored for each question in the survey, in comparison with national benchmark results. It should be used to understand the trust’s performance, and to identify areas for improvement.

National spreadsheets presenting the percentage of respondents from each trust providing a particular response to each survey question are available on the Healthcare Commission website at http://www.healthcarecommission.org.uk/nationalfindings/surveys/patientsurvey/nhspatientsurvey2006.cfm

These should be used to understand each individual trust’s detailed survey results. A briefing note that provides a commentary on the key national findings and highlights changes from previous surveys is also available. These documents were produced by the Acute Coordination Centre at the Picker Institute Europe.

Similar surveys of adult inpatients were also carried out in 2002, 2004 and 2005. They are part of a wider programme of patient surveys, which covers a range of topics including community mental health, health services for children and young people, accident and emergency care for adults, and ambulance and primary care services. To find out more about our programme, please visit our website.

About the survey

Our fourth survey of adult inpatients involved 167 acute and specialist NHS trusts. We received responses from more than 80,000 patients. Patients were
eligible for the survey if they were aged 16 years or older, had at least one overnight stay and were not patients of maternity or psychiatric services.

The benchmark reports are based on all responding patients aged 16 years and over. In 2004, the Healthcare Commission carried out a separate survey of children and young people (aged 0-17 years) and consequently only those aged 18 years and over were included in the sample for the 2004 adult inpatients survey. As a result, the benchmark reports for the 2004 survey were based on patients aged 18 years and over and are therefore not directly comparable to the reports for the 2006 survey presented here.

In 2006, Moorfields Eye Hospital NHS Foundation Trust was excluded from the survey as all patients were treated as day cases.

**Interpreting the report**

These benchmark reports are calculated by converting responses to particular questions into scores. For each question in the survey, the individual responses were scored on a scale of 0 to 100. A score of 100 represents the best possible response.¹ Therefore, the higher the score for each question, the better the trust is performing.

A ‘scored’ questionnaire showing the scores assigned to each question can be downloaded from our website. Please note: the scores are not percentages, so a score of 80 does not mean that 80% of people who have used services in the trust have had a particular experience, but that the trust has scored 80 out of 100. Percentage results are presented in the national spreadsheets, which are available on our website.

The graphs included in this report display the scores for this trust, compared with national benchmarks. Each bar represents the range of results for each question across all trusts that took part in the survey. In the graphs, the bar is divided into three sections:

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

¹ Trusts will have differing profiles of patients. For example, one trust may have more male inpatients than another trust. This can potentially affect the results because some people tend to answer questions in a different way than others. Therefore, the results have been weighted by the age, sex and mode of admission (emergency or elective) of respondents to ensure that no trust will appear better or worse than another because of its sample profile. The results for each trust are standardised, so that their age-sex-admission type profile reflects the national age-sex-admission type distribution (based on all of the respondents to the survey). This enables results from trusts with different profiles of patients to be compared.
A white diamond shows the score for this trust. If the diamond is in the green section of the bar, the trust is among the top 20% of trusts in England for that question.

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

Since the score is based on a sample of inpatients in a trust rather than on everyone, the score may not be exactly the same as if everyone had been surveyed and had responded. Therefore a confidence interval is calculated as a measure of how accurate the score is. We can be 95% sure that if everyone in the trust had been interviewed, the ‘true’ score would fall within this interval.

The diamond is not shown for questions answered by fewer than 30 people because the uncertainty around the result would be too great. When identifying trusts with the highest and lowest scores and thresholds, trusts with fewer than 30 respondents have not been included.

At the end of the report you will find the data used for the charts, and background information about the patients that were surveyed.

Notes on specific questions

**Q16 and Q18** The information collected by Q16 (When you were first admitted to a bed on a ward, did you share a sleeping area, for example a room or bay, with patients of the opposite sex?) and Q18 (After you moved to another ward (or wards), did you ever share a sleeping area, for example a room or bay, with patients of the opposite sex?) are presented together to show whether the patient has ever shared a sleeping area with patients of the opposite sex. The combined question is numbered in this report as Q16 and has been reworded as ‘Did you ever share a sleeping area with patients of the opposite sex?’

In addition, the information based on these questions cannot be compared to similar information collected in the previous inpatient surveys. This is because the 2006 results have excluded patients who have stayed in a critical care area, which almost always accommodates patients of both sexes. For further details, please see the ‘scored’ questionnaire which shows the scores assigned to each question. This may be downloaded from our website at the address provided in the ‘Further Information’ section below.

**Q55 and Q56** Information from Q54 (On the day you left hospital, was your discharge delayed for any reason?) has been used to score the results for Q55 (What was the main reason for the delay (in discharge?) and Q56 (How long was the delay (in discharge?)). Further scoring information is available from the questionnaire posted on our website.

**Further information**

Full details of the methodology of the survey can be found at
More information on the programme of NHS patient surveys is available on the patient survey section of the website at http://www.healthcarecommission.org.uk/nationalfindings/surveys/patientsurveys.cfm

The 2006 survey of adult inpatient results, questionnaire and scoring can be found at http://www.healthcarecommission.org.uk/PatientSurveyInpatient2006

The 2005 survey of adult inpatient results can be found at http://www.healthcarecommission.org.uk/nationalfindings/surveys/patientsurveys/nhspatientsurvey2005/inpatientsurvey2005.cfm

The 2004 survey of adult inpatient results can be found at http://www.healthcarecommission.org.uk/PatientSurveyInpatient2004

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Key personnel

Sally Donovan
Jason Boyd
Chris Graham

Adherence to the procedures outlined in this document

It is not permissible to deviate from the agreed protocol as set out in this guidance manual, for example, by offering financial inducements or lottery prizes to respondents. Similarly, we do not recommend translation of questionnaires into other languages. More guidance on how to reach ethnic minority groups can be found in Section 8. The terms of the ethical approval do not permit these types of alteration. Furthermore, such alterations might mean that the comparability of the survey would be compromised, and such results may not be acceptable for computation of the Annual Health Check for that trust. If trusts want to make any adjustments to the method set out in this guidance, they will need to seek local research ethics approval, and check with the Acute Co-ordination Centre that the proposed alteration would not compromise comparability.

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 and contractors directly to inform them of the change.

This document is available from the Acute Co-ordination Centre website at:

www.NHSSurveys.org

* Previously the NHS Patient Survey Advice Centre
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1 Introduction: patient feedback and the NHS Plan

1.1 The Healthcare Commission

The national patient survey programme is owned by the Department of Health and has been operating since 2002. The Healthcare Commission administers the programme. The Healthcare Commission exists to inspect the quality and value for money of healthcare, to equip patients and the public with the best possible information about the provision of healthcare, and to promote improvements in healthcare. Patients’ experience of health services is at the heart of the Healthcare Commission’s work: we want health services to be shaped by what matters most to patients and the public.

By ensuring that organisations carry out these surveys in a consistent and systematic way it is possible to build up a national picture of people’s experience and, with care, to compare the performance of different organisations, change over time, and variations between different patient groups. As well as supplying the Department of Health with data for reporting to parliament, the survey programme provides an important source of data for screening self-assessment declarations in the annual health check. Additionally, the surveys are expected to inform local improvement activity; they are seen as an important source of information for people to help them choose between providers and for informing commissioners of services.

1.2 The Acute Co-ordination Centre (ACC)

The Acute Co-ordination Centre for the NHS patient survey programme is based at the Picker Institute and works under contract to the Healthcare Commission to design, test, and co-ordinate the acute survey programme. We ran the Advice Centre for the NHS Patient Survey Programme from 2002 until 2005.

1.3 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 healthcare, 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 healthcare is delivered. This manual is designed to help staff in acute NHS trusts to obtain patient feedback through patient surveys. It also provides guidance on how you may use the information you gather in quality improvement programmes and for monitoring performance. 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.

1.4 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 NHS Plan (2000) 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 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 the Healthcare Commission’s programme of reviews and inspections.

### 1.5 The Annual Health Check

Information drawn from the core questions in the Inpatient surveys is one of the elements used by the Healthcare Commission to measure performance of trusts against the national core and developmental standards. These indicators will be used in the Annual Health Check of acute and specialist trusts in England, due for publication in summer 2007.

In addition to the performance assessment, the Healthcare Commission 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 an inpatient survey in a consistent way, the Healthcare Commission is building up a detailed picture of patients’ experiences in acute NHS trusts. Also, by repeating the same surveys on an annual basis, trusts will be able to monitor their own performance over time.

The Healthcare Commission intends to archive the survey data with the UK Data Archive after the analysis is completed and published. This will be done with appropriate safeguards that ensure patient confidentiality.

### 1.6 Basic requirements for NHS trust inpatient survey

For comparisons between and within trusts to be accurate, fair and effective, it is essential that the surveys are 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 Acute Co-ordination Centre by **25th August 2006** and tell them who is carrying out your survey (ie whether it will be carried out by an approved contractor or in-house), and who in your trust will be responsible for monitoring the surveys’ progress (e-mail: acute.data@pickereurope.ac.uk).
- The survey must be carried out using a postal questionnaire.
- The samples of patients must consist of the most recent consecutive discharges up to the last day of **either June 2006 or July 2006 or August 2006** as outlined in Section 10 – Compiling a list of patients.
- The sampling procedure set out in this guidance must be followed. To do this, you will need to work closely with the person who draws the sample, and check carefully that this guidance has been adhered to. For further details see Section 10 – Compiling a list of patients.
- Sample data must be submitted to the Acute Co-ordination Centre for final checks before mailing as outlined in Section 11 – Final sampling inspection by the Acute Co-ordination Centre. We need to receive these sample files between **4th and 28th of September 2006**.
• You should aim to obtain the highest response rate possible. For this survey, the target response rate is 60% (that is, you should get 500 returned questionnaires from the 850 mailed out). Three mailings will be necessary to achieve this target. However, trusts should facilitate higher response rates through maximising their collection period and publicising the survey.

• Weekly submissions of details of response rates and helpline calls to the Acute Co-ordination Centre will start from 21st September. A spreadsheet has been created for this purpose. For further details see Section 12 – Weekly monitoring.

• The questionnaire must include the 75 core questions. See Section 13 – Publicising the survey.

• The standard covering letters and reminder letters (which can be found under the Inpatients section of the NHSSurveys website) must be used as outlined in Section 15 – Materials.

• Two reminders must be sent to non-responders, even if a 60% response rate is already achieved outlined in Section 16.6 – Sending out reminders.

• The data must be checked carefully for errors before submitting it to the Acute Co-ordination Centre. Specific advice on how to carry this out is included in Section 17.4 – Checking for data errors.

• The data from the core questions, and the required information about the patient sample, must be submitted to the Acute Co-ordination Centre in the form outlined in Section 17.5 – Submitting data to the ACC by 8th December 2006.

• Two paper copies each of the questionnaire you used and the covering letters for each mailing must be submitted to the Acute Co-ordination Centre in the form outlined in Section 17.5 – Submitting data to the ACC by 15th December 2006.

• You must keep hard paper copies (or scanned images of all of the pages of the questionnaires, including the front page) of all questionnaires returned to you until 30th April 2007 but please do not send these to the Acute Co-ordination Centre. These returned questionnaires may be needed to audit the data sent to the ACC.

1.7 Why you need 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 13 and 18 to 20 of this guide. Sections 15, 16 and 17 cover the practicalities of mailing out the survey, following-up responses and processing data, and submitting it to the Acute Co-ordination Centre. These sections will be most relevant to approved contractors, or trusts undertaking the surveys themselves. Section 14 contains details of the questions in the core and bank questionnaires.
2 Setting up a project team

Whether you choose to do the survey in-house, or to use an approved contractor, we recommend you set up a project team to assist you. 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.

We suggest:

• **Establishing a workgroup.** Put together a small team of people who are key stakeholders and involve them in decisions. Groups to consider include:
  - Board members
  - Doctors, nurses and other health care staff
  - Managers
  - Medical records personnel or Patient Administration System (PAS) staff
  - Patients and carers
  - Members of patient groups with a special interest in the trust
  - Caldicott Guardian
  - Staff or directors responsible for:
    - Clinical governance
    - Patient advice and liaison service (PALS)
    - Quality improvement
    - Strategic planning.

• **Involving 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.

• **Keeping everyone informed.** Notify as many people as possible about ideas and activities. All departments in the trust should be made aware when a survey is being conducted, in case patients ask questions.

• **Not overlooking front-line staff.** These people who have the most frequent direct contact with patients.
3 What’s new for 2006?

The 2006 inpatient questionnaire has been kept as similar as possible to the 2005 inpatient questionnaire to allow comparisons to be made between survey years. The changes which have been made are:

The question “During your stay in hospital, did you ever share a room or bay with patients of the opposite sex?” has been removed. This has been replaced with five questions to clarify the issue of sharing rooms or bays with patients of the opposite sex. These questions are:

- “While in hospital, did you ever stay in a critical care area (Intensive Care Unit, High Dependency Unit or Coronary Care Unit)?”
- “When you were first admitted to a bed on a ward, did you share a sleeping area, for example a room or bay, with patients of the opposite sex?”
- “During your stay in hospital, how many wards did you stay in?”
- “After you moved to another ward (or wards), did you ever share a sleeping area, for example a room or bay, with patients of the opposite sex?”
- “While staying in hospital, did you ever use the same bathroom or shower area as patients of the opposite sex?”

Three further questions have been removed from the survey as they demonstrated a ‘ceiling effect’ ie extremely high scores with very small differences between trusts. These questions are therefore of little use in measuring improvement in services. The questions were:

- “Overall, did the ambulance crew treat you with respect and dignity?”
- “Did you think the order in which patients were seen in the Emergency Department was fair?”
- “When you were told you would be going into hospital, were you given enough notice of your date of admission?”

Two more questions were added from the question bank that can be used to measure standards:

- “Were you given information on how you could complain about the hospital care you received?”
- “Were you offered a choice of food?”

Approved contractors: Following the recent tender process, there have been some changes to the list of approved contractors. The revised list can be found in Section 5.

Data protection guidance: The guidelines on data protection, which are designed to prevent the disclosure of patient information, have been revised for all surveys in the NHS Patient Survey Programme. These are discussed further in Section 6.

Sample checking: Once patient samples have been generated and checked (by the trust, by the NHS Strategic Tracing Service (NSTS), and by the approved contractor if applicable) the samples must then be submitted to the Acute Co-ordination Centre for final inspection. Mailing cannot begin until the sample has been approved by the Acute Co-ordination Centre. This is discussed further in Section 11.

Weekly submissions: Weekly submissions of response rates (outcomes) and helpline monitoring information must be made by each trust taking part in the inpatient survey 2006. These should be emailed to the Acute Co-ordination Centre using the spreadsheet found on our website. This is discussed further in Section 12.
New **Handbooks** on ‘Sampling’, ‘Data Protection’ and ‘Approved contractors and honorary contracts’ can be found on the NHSSurveys website. These are intended for trust staff who are involved in some aspects of the inpatient survey 2006 (eg drawing the patient sample, comparing contractor pricings, etc) but who will not be managing the entire process. Those co-ordinating the survey for the trust (either in-house or an approved contractor) must be familiar with the full version of the guidance as this sets out **ALL** requirements for the survey.

**Glossary:** A glossary has been included at the end of this guidance manual.
4 Deciding whether to use an approved contractor or carry out the survey in-house

Trusts may choose to carry out their surveys in-house, or to commission an approved contractor to carry out the work for them. We do not recommend you carry out large-scale surveys such as these 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 contractor:

- Costs
- Internal resources/Expertise
- Timing
- Quality and confidence in the findings

4.1 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 include the cost of staff time, including salary and fringe benefits, and time spent away from other work. Please note that weekly submission will be required for each trust taking part in the inpatient survey 2006, involving increased staff time for both trusts and contractors.

Stationery and postage

You will need to cover the cost of stationery and postage for three mailings. The first mailing will go out to 850 patients and the second and third mailings will be sent only to non-responders. (See Section 15 – Materials for more details.) You will 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

There is a charge for obtaining a freepost license which enables you to print a freepost address on return envelopes so that respondents can send back completed questionnaires at no cost to themselves. You will also be charged for each returned questionnaire. (For details, see 16.1 - Setting up a FREEPOST address).
Freephone service

This service gives patients easy access to advice and staff who can reassure them on any concerns they have about the survey. The cost of setting up such a service needs to be included. (For details, see 16.2 - Setting up a FREEPHONE line).

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 for which there would be a charge. We recommend you 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.

4.2 Internal resources

To carry out a survey effectively, the following areas of experience and skills are needed:

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

4.3 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. If you commission an approved contractor to carry out the survey, you should ensure that appropriate and realistic deadlines are set.

4.4 Quality and confidence in the findings

It is important to remember that the results of the survey will be used not only within the trust to identify areas for improvement but also by the Healthcare Commission and DH to contribute to performance assessment and for use in the ‘choosing your hospital’ booklet.

It is therefore essential that the data are as accurate and reliable as possible and that the information is gathered in the same way for all trusts. Using the expertise of an approved contractor may add credibility to the survey findings in the eyes of staff, patients and the general public.

When you have decided who will carry out your survey, ie an in-house team or an approved contractor, you must inform the Acute Co-ordination Centre by 25th August 2006.
5 Commissioning a survey from an approved contractor

The framework agreement set up by the Healthcare Commission 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, eg FREEPHONE line
- Data entry, cleaning data and providing data to Acute Co-ordination Centre by the deadline
- Preparing standard reports for trusts.

Twelve organisations have been approved by the Healthcare Commission to carry out surveys for the NHS patient survey programme. Trusts may commission any one of these contractors without further tendering the survey work. Before committing to a contractor, you are advised to check exactly what is covered within the cost quoted.

Information about each of these organisations, including their prices, can be found on the NHSSurveys website.

5.1 List of approved contractors

The following contractors have approved status for work on the national patient experience surveys programme:

**BMG Research**

**Contacts:** Dawn Hands

Holt Court  
Heneage Street West  
Aston Science Park  
BIRMINGHAM  
B7 4AX

Tel: 0121 333 6006  
Fax: 0121 333 6800  
E-mail: dawn.hands@bmgresearch.co.uk  
Website: www.bmgresearch.co.uk

**GFK NOP**

**Contact:** Sarah McHugh, Joy Mhonda and Lisa Endersbee

GFK NOP  
Ludgate House  
245 Blackfriars Road  
London  
SE1 9UL
Tel: 0207 890 9000 (Switchboard)
Fax: 0207 890 9744
E-mail: sarah.mchugh@gfk.com, joy.mhonda@gfk.com, lisa.endersbee@gfk.com
Website: www.gfknop.co.uk

Ipsos MORI
Contact: Jessica Elgood

Ipsos MORI
79-81 Borough Road
London
SE1 1FY

Tel: 0207 347 3000
Fax: 0207 347 3800
E-mail: Jessica.elgood@ipsos-mori.com
Website: www.mori.com

Marketing Sciences
Contact: Eileen Sutherland

Marketing Sciences
8 Clement Street
Winchester
Hampshire
SO23 9DR

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

MSB Ltd
Contact: Don Porter

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

Tel: 01344 876 300
Fax: 01344 873 677
E-mail: Don@msbconsultancy.com
Website: www.msbconsultancy.com
The National Centre for Social Research

Contacts: Marian Bolden

National Centre for Social Research
Kings House
103-135 Kings Road
Brentwood
Essex
CM14 4LX

Tel: 01277 690101
Fax: 01277 226844
E-mail: M.Bolden@natcen.ac.uk
Website: www.natcen.ac.uk

NHS Partners

Contact: Cheryl Kershaw

NHS Partners
30 Victoria Ave
Harrogate
North Yorkshire
HG1 5PR

Tel: 01423 720212
Fax:
E-mail: Cheryl.kershaw@nhspartners.org.uk
Website: www.nhspartners.org.uk

Patient Dynamics

Contacts: Andrew Smith and Delia Knox

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

Tel: 01494 536346
Fax: 01494 536146
E-mail: andrew@patientdynamics.org.uk; delia@patientdynamics.org.uk
Website: www.patientdynamics.org.uk

Patient Perspective

Contact: Stephen Bruster

25 Grove St
Oxford
OX2 7JT

Tel: 01865 420027
Fax: 01865 426831
E-mail: Stephen.bruster@PatientPerspective.org
Website: www.PatientPerspective.org
Picker Institute Europe

Contacts: Tim Markham, Karen Bullen, Bridget Hopwood, Sheena MacCormick, 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

Quality Health

Contacts: Dr Reg Race and Kerry Hibberd

Quality Health
Sutton Manor
Palterton Lane
Sutton Scarsdale
Chesterfield
Derbyshire
S44 5UT

Tel:    01246 856263
Fax:    01246 851143
Email:  Reg.Race@Quality-Health.co.uk; kerry.hibberd@Quality-Health.co.uk
Website: www.quality-health.co.uk

SNAP surveys

Contact: Tamara Gooderham

SNAP Surveys
Mead Court
Cooper Road
Thornbury
Bristol
BS35 3UW

Tel:    01454 280860
Fax:    01454 281216
Email:  tgooderman@snapsurveys.com
Website: www.snapsurveys.com
5.2 Contracts

Model honorary contracts have been provided by the Healthcare Commission to be used as templates for agreements between the trust and the approved contractor. These can be found on the NHSSurveys website in both Word document and template formats. The four documents that are available are:

- A briefing note about the honorary contracts
- Guidance about the honorary contracts
- The honorary contract between the trust and the approved contractor
- The honorary contract between the trust and individual staff members of approved contractors

These are designed as model contracts and trusts and approved contractors may agree on the wording and content of their own contracts. We suggest 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 (division of responsibilities)
- The main contact at the survey provider and the individual at the trust responsible for managing the project
- A timetable showing the dates when each task is to be carried out and by whom
- The version of the questionnaire to be used (core or enhanced)
- 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 approved contractors
- The costs and a payment schedule.
6 Data protection and confidentiality

When carrying out your survey, you will need to ensure that you comply with the Data Protection Act 1998, and ensure that all responses are kept confidential. You will also need to comply with the NHS Code of Practice on Confidentiality (2003), which incorporates the Caldicott principles†. It is your legal responsibility to ensure that you meet any guarantees of anonymity or confidentiality made in covering letters and on the questionnaire form. It will also be necessary to establish appropriate contractual arrangements with any contractors. Your trust’s Caldicott guardian and legal advisors will be able to advise you on these matters.

New guidelines on the use and security of the data collected have been agreed by the Healthcare Commission and the co-ordination centres for the national NHS staff and patient survey programmes. These guidelines will help to ensure that data are handled in a manner most in keeping with the spirit of the Data Protection Act 1998 and the Market Research Society’s Guidelines for social research (2005). They have implications for approved contractors and for NHS trusts conducting surveys in-house.

Their website below has further information:
http://www.dh.gov.uk/PolicyAndGuidance/InformationPolicy/PatientConfidentialityAndCaldicottGuardians/fs/en

Further information about the Data Protection Act 1998 can be found at http://www.ico.gov.uk


6.1 Statements of compliance with data protection

In-house surveys

Each NHS trust has a Caldicott Guardian responsible for overseeing proper use of patient data. If you are conducting the survey in-house then, before drawing the sample, you must submit a formal declaration (see Appendix 1), signed by the Caldicott Guardian and survey lead(s) for the trust, to the ACC. This declaration will certify that data shall only be displayed, reported, or disseminated in compliance with the new guidelines (see Section 6.5). Templates for these declarations are available on the website containing the survey guidance (www.NHSSurveys.org). You must wait for confirmation of receipt from the co-ordination centre before you draw your sample.

† 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

You should take particular care to ensure that your use of patient data in carrying out the survey, complies with these 6 principles. In particular, you should be aware of the flows of patient data, and the issues which these present.

The Caldicott guidance and principles were incorporated into the NHS code of practice on confidentiality.
If the Caldicott Guardian is unable to make such a declaration, then the trust must use an approved contractor to ensure that appropriate standards of confidentiality data protection are maintained.

Approved contractors

The framework agreement between the approved contractors and the Healthcare Commission contains clauses stating that the approved contractor will comply with the Data Protection Act so no declaration is required if a trust appoints a contractor from the approved list.

6.2 Patients’ names and addresses

In order to comply with the Data Protection Act 1998 and common law duty of confidence, NHS trusts should not release the names, addresses or any other personal details of patients to anyone who is not employed by the trust, unless consent has been obtained from each patient. This includes releasing names and addresses for the purpose of mailing survey questionnaires to patients. The honorary contract (see Section 6.3) allows approved contractor staff to view this information without infringing the Data Protection Act 1998. Please note that under the new data protection guidelines for patient surveys, the following principles must be followed:

- All of the Caldicott principles must be satisfied
- The personal data should be sent to the approved contractor in the form of a password-protected database or sent to the contractor using a Healthcare Commission approved secure uplink. The password should be verbally given to a named individual at the approved contractor. The trust should save the database onto a CD-ROM or diskette, placed in a single sealed envelope or other container, annotated “Addressee Only”, and sent this to the approved contractor by recorded delivery through the Royal Mail or through a courier service.
- Names and addresses may be sent by Trusts to contractors over the Internet using an encrypted session. Trusts/contractors must gain prior approval from the Healthcare Commission for their particular methods and choice of products, and must undertake to keep their products up to date to ensure that security is effective.
- If the Transport Layer Security (TLS) or Secure Sockets Layer (SSL) protocol (for example as with HTTPS or SFTP) is to be used, a key size of 256 bits should be used whenever possible. A key size of at least 128 bits must be used.
- This procedure is in accordance with the guidelines for sharing restricted information as set out in the Healthcare Commission’s handbook for staff: Handling information at the Healthcare Commission.

Remember: if the data contains patient names and addresses, this can only be sent to the contractor by CD-ROM or diskette, or via a Healthcare Commission approved encrypted method.

Two common methods are practised by trusts, and advised by the Healthcare Commission, working with approved 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 Section 16.
2) Alternatively, with the agreement of the trust’s Caldicott Guardian, you may set up a written agreement between the trust and the external contractor. The Healthcare Commission has developed a set of contracts for trusts and approved contractors carrying out the survey. The honorary contract makes named staff members of the approved contractor unpaid employees of the trust, allowing the trust to transfer patient data in a way that does not compromise patient confidentiality, and to avoid the need for each trust to develop its own arrangements. It is strongly recommended that these documents are reviewed by each trust and approved contractor to ensure they are satisfied with them, and to amend where required.

6.3 Model contract

A model contract has been drawn up by the Healthcare Commission. This is an agreement between the approved contractor and the trust contracting them. By signing it, the approved contractor is obliged to keep the information confidential at all times, and to comply with the Data Protection Act 1998. The model contract also ensures that approved contractor staff members sign and abide by the honorary contract. The honorary contract is set up between the trust and those members of the approved contractor staff who will have access to patients’ information. The honorary contract describes how patients’ personal data will be sent to the approved contractor, and how the data can be used. It also ensures that only those members of staff named in the contract will have access to the data.

The model contract in Word format is available under the Inpatients section of the website containing the survey guidance (www.NHSSurveys.org).

6.4 Patient anonymity

In-house surveys

It is important to ensure that any claims you make about patient anonymity are accurate; and you are obliged by law to honour any statements that you do make. 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 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 patients’ responses should be seen by contractor staff only. As long as the response data supplied to trusts do not include patient record numbers or any other detail that allows individuals to be identified or linked, it can reasonably be claimed that patients’ responses are anonymous.

6.5 Patient confidentiality

It is essential that any patient survey is conducted in such a way that patient confidentiality is respected and given a high priority. The covering letters that accompany the mailed questionnaires inform patients that their name and address will never be linked to their responses. Furthermore, patients’ 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 year of birth, sex and ethnic group are known from their survey responses, it might be possible to use this information to identify them. It would be unlawful to provide staff who may have had
contact with respondents any information that would allow these respondents to be identified. The following recommendations are made:

**Trust level**

1) The raw data set should not be provided to any staff at the trust other than the Caldicott Guardian and survey leads recorded on the declaration of compliance (see Section 6.1)
2) Additional data analysts may be added later by a second submission of the declaration of compliance to the Acute Co-ordination Centre (see Appendix 2). Additional data analysts cannot view the raw data until approval has been received from the ACC.
3) If data are to be presented to trust staff who have not signed the declaration using the declaration of compliance, only the aggregated totals for each question should be provided. If analysis by subgroup is carried out, the results for any group consisting of fewer than 20 respondents should be suppressed (replaced by a dash). The data should be presented as in the following example. In this case, responses for the ‘Mixed’ and ‘Asian’ ethnic groups are suppressed (though the subgroup totals are shown):

<table>
<thead>
<tr>
<th>Ethnic group</th>
<th>Q20. Were you ever bothered by noise at night from hospital staff?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>White</td>
<td>81</td>
</tr>
<tr>
<td>Mixed</td>
<td>-</td>
</tr>
<tr>
<td>Asian</td>
<td>-</td>
</tr>
<tr>
<td>Black</td>
<td>79</td>
</tr>
<tr>
<td>Chinese or other</td>
<td>85</td>
</tr>
</tbody>
</table>

4) Do not present response information (including comments) in a form that allows an individual patient to be identified by the group receiving the information. For example, if you are presenting the results of a small number of patients, make sure that it will not be possible for the reader/audience to identify individual patients from their responses, and pay particular attention to the patients’ free text comments in this context.

The electronic file containing the patients’ names and addresses should be stored securely (ie password protected). Access to the file should be given only to those individuals who have signed the declaration of compliance.

**Approved contractor**

1) Approved contractors must not provide raw data to the trust as a matter of course.
2) If the trust has a particular need for the raw data from the survey from the approved contractor, the contractor may provide an abridged version of this dataset to the trust upon request, providing that the steps below are undertaken first:
   a. The contractor must delete the two variables pertaining to ethnicity (eg both sample and response variables)
   b. The contractor must band year of birth into five age groups (18-35, 36-50, 51-65, 66-80, 80+). This process should be repeated separately for both sample and response variables. The original year of birth variables (eg those specifying an exact year rather than age group) must then be deleted
   c. Additional information specific to a survey that can be used to identify individual patients must also be removed. For example, admission and discharge dates on the adult inpatient survey must be removed but length of stay can be calculated from the admission and discharge dates and provided to trusts.
d. Verbatim comments that could lead to any staff identifying respondents must be removed, eg those mentioning patient, staff, ward or unit names‡.
e. Receive confirmation from the trust that they have destroyed the names and addresses of the sampled patients, otherwise they will be able to identify individual patients by matching up the patient record number/serial numbers on the name and address list to those in the raw data file.

These steps MUST be followed before supplying raw data to trusts. This is to prevent the disclosure of a patients’ identity by specific demographic factors. Different arrangements govern the supply of raw data to the co-ordination centres. The arrangements are described in full in Section 17. The response data will be anonymous when passed to the Acute Coordination Centre and Healthcare Commission, and published and archived results will not identify patients.

If data are to be presented to trust staff, only the aggregated totals for each question should be provided. If analysis by subgroup is carried out, the results for any group consisting of fewer than 20 respondents should be suppressed. The data should be presented as in the following example. In this case responses for the ‘Mixed’ and ‘Asian’ ethnic groups are suppressed (though sub-group totals are shown):

<table>
<thead>
<tr>
<th>Ethnic group</th>
<th>Yes</th>
<th>No</th>
<th>Total responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>81</td>
<td>19</td>
<td>261</td>
</tr>
<tr>
<td>Mixed</td>
<td>-</td>
<td>-</td>
<td>8</td>
</tr>
<tr>
<td>Asian</td>
<td>-</td>
<td>-</td>
<td>18</td>
</tr>
<tr>
<td>Black</td>
<td>79</td>
<td>21</td>
<td>52</td>
</tr>
<tr>
<td>Chinese or other</td>
<td>85</td>
<td>15</td>
<td>26</td>
</tr>
</tbody>
</table>

Furthermore, do not present response information (including comments) in a form that allows an individual patient to be identified by the group receiving the information. For example, if you are presenting the results of a small number of patients, make sure that it will not be possible for the reader/audience to identify individual patients from their responses, and pay particular attention to the patients’ free text comments in this context.

The electronic file containing the patients’ names and addresses should be stored securely (ie password protected). Access to the file should be given only to those individuals who have signed honorary contracts.

6.6 Sharing of survey data between contractors

If a Trust will be using a different approved contractor than in the last survey year, contractors are permitted to transfer an unabridged version of the data set if there is a clear need to use the data from the previous year’s surveys to allow year-on-year comparison.

‡ Please be aware that there are exemptions allowing disclosure, such as the prevention of crime exemption which might allow disclosure of free text describing criminal matters actual or threatened. Neither the Healthcare Commission nor the ACC can offer legal advice on these matters; the contractor or trust must seek its own independent legal advice before disclosing patients’ comments to trusts.
6.7 Storing completed questionnaires

Completed questionnaires must be stored in a separate location to lists of patients’ names, and the questionnaires kept until 30th April 2007. All mailing lists of patients’ names and addresses should be stored on a separate computer to that containing survey data. Mailing lists of patients’ names and addresses should be destroyed when the mailing process is complete.
7 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.

7.1 Ethical approval for the inpatient survey

Multi-Centre Research Ethics Committee (MREC) approval has been obtained for the inpatient core questionnaire, the question bank, and the covering and 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.

Trusts do not, therefore, need to seek individual ethical approval for this survey. If you wish, you can send your Local Research Ethics Committee(s) (LREC) a copy of the MREC approval letter, but you are not required to do this and you do not need to wait for confirmation or approval from the LREC before starting your survey. The MREC letter can be downloaded from the NHSSurveys website.

Further information on the ethical approval process can be found at Central Office for Research Ethics Committees or by e-mailing queries@corec.org.uk.

7.2 Research governance requirements

The Research Governance Framework (2002, 2003, 2005) aims to ensure that health and social care research is conducted to high scientific and ethical standards. It spells out standards and the 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 Healthcare Commission, 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 Department of Health has confirmed to the Healthcare Commission 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 sponsoring. As this national patient survey has multi-centre research ethics committee approval and the Healthcare Commission takes responsibility for it as sponsor, this would duplicate work and delay implementation unnecessarily.

The following table has been prepared by the Healthcare Commission and is taken from Section 3.10 of the Research Governance Framework for health and social care (2005). The left-hand column sets out the responsibilities of organisations providing care and the right-hand columns sets out the arrangements made by the Healthcare Commission for patient surveys. If you are required to seek approval from your research governance lead, you are advised to present this information to your Research and Development Manager in support of your request.
7.3 Responsibilities of NHS organisations who are carrying out research

<table>
<thead>
<tr>
<th>Research Governance Framework</th>
<th>Healthcare Commission sponsored patient surveys</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retain responsibility for the quality of all aspects of participants’ care whether or not some aspects of care are part of a research study.</td>
<td>The survey is carried out on the experiences of patients after they have received the care so this does not apply.</td>
</tr>
<tr>
<td>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.</td>
<td>All Chief Executives are informed of the proposals of the survey. Similar letter has been sent to the Research and Development Managers of the trusts.</td>
</tr>
<tr>
<td>Ensure patients or users and carers are provided with information on research that may affect their care.</td>
<td>The survey does not affect the care of the patients. Anonymised results are used for the Annual Health Check and local quality improvement initiatives. Detailed guidance is issued to survey leads regarding the publicity of the results and its impact on patient care.</td>
</tr>
<tr>
<td>Be aware of current legislation relating to research and ensure that it is implemented effectively within the organisation.</td>
<td>This requirement is not specific to this survey.</td>
</tr>
<tr>
<td>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.</td>
<td>The Healthcare Commission 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.</td>
</tr>
<tr>
<td>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.</td>
<td>The Healthcare Commission 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.</td>
</tr>
<tr>
<td>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.</td>
<td>Detailed guidance is issued to all the trusts, which spells out the responsibilities of all parties involved in the survey.</td>
</tr>
<tr>
<td>Maintain the necessary links with clinical governance and/or best value processes.</td>
<td>The guidance notes very strongly recommend the trusts to maintain these links and follow best practice evidence.</td>
</tr>
<tr>
<td>Research Governance Framework</td>
<td>Healthcare Commission sponsored patient surveys</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>-------------------------------------------------</td>
</tr>
<tr>
<td>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.</td>
<td>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.</td>
</tr>
<tr>
<td>Put and keep in place systems to identify and learn from errors and failures.</td>
<td>The Healthcare Commission also undertakes consultations with the trusts in order to ensure that the errors and failures are reported back to the Healthcare Commission. The survey programme is constantly evaluated and reviewed in the light of these.</td>
</tr>
<tr>
<td>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.</td>
<td>This requirement is not specific to this survey.</td>
</tr>
<tr>
<td>Ensure that significant lessons learnt from complaints and from internal enquiries are communicated to funders, sponsors and other partners.</td>
<td>The Healthcare Commission maintains a helpline facility, which can be used by patients or trusts to report any complaints. Similar arrangements are in place with the Acute Co-ordination Centre who are commissioned by the Healthcare Commission to co-ordinate the patient surveys.</td>
</tr>
<tr>
<td>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.</td>
<td>Not applicable to the patient survey. Patient safety is not compromised, this being a postal survey.</td>
</tr>
<tr>
<td>Permit and assist with any monitoring, auditing or inspection required by relevant authorities.</td>
<td>The results of the surveys are used for monitoring of core and developmental standards in the Annual Health Check.</td>
</tr>
</tbody>
</table>

§ 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).
8 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 plain 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 since it is not possible 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.

The Healthcare Commission has commissioned further work to assess alternative methods for seeking the views of ethnic minority groups for future surveys. There are a number of strategies you can adopt in the meantime to facilitate the process of collecting ethnic minority views within this survey:

- It is good practice to offer help or interpretation services to those who might require them. You can do this by subscribing to a specialist interpreting service, most of who offer telephone interpretation on a pay-as-you-go basis. This normally involves a three-way conversation between you (or your helpline operator), the patient and the interpreter. (Note that trusts may already have arrangements with such a service.)

- A multi-language leaflet template is available on our site, and this can be included with your first and third mailings. Trusts and approved contractors can use this leaflet by inserting their appropriate helpline number. This gives directions in the 20 most common non-English languages spoken in England and also in EasyRead (routed to a separate number run by Mencap to help those with learning disabilities).

- 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.
## 9 Timetable

The time taken to complete the survey process will depend on many factors. The survey period has been extended by two weeks for 2006, now allowing a total of 14 weeks. Dissemination of the results to all staff will take considerably longer. If you commission an approved contractor, much 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.

<table>
<thead>
<tr>
<th>Week</th>
<th>Task</th>
<th>See Section</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Inform Acute Co-ordination Centre who is carrying out your survey by 25th August 2006 (in-house or using an approved contractor)</td>
<td>4 &amp; 5</td>
</tr>
<tr>
<td>1</td>
<td>Decide on questions to be included in the survey (ie select from question bank or use the core questionnaire)</td>
<td>14</td>
</tr>
<tr>
<td>1</td>
<td>Draw sample of patients to be included in the survey</td>
<td>10</td>
</tr>
<tr>
<td>1</td>
<td>Check sample for deceased patients using hospital records</td>
<td>10.2</td>
</tr>
<tr>
<td>1</td>
<td>Submit sample list to NSTS to check for deceased patients</td>
<td>10.7</td>
</tr>
<tr>
<td>1 - 4</td>
<td>Submit anonymised sample to Acute Co-ordination Centre before starting mailing process</td>
<td>11</td>
</tr>
<tr>
<td>1</td>
<td>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</td>
<td>5.2 &amp; 15.2</td>
</tr>
<tr>
<td>1</td>
<td>Print questionnaires and covering letters.</td>
<td>15</td>
</tr>
<tr>
<td>2</td>
<td>Set up FREEPOST address and helpline</td>
<td>16.1 &amp; 16.2</td>
</tr>
<tr>
<td>2</td>
<td>Establish system for responding to telephone enquiries</td>
<td>16.2</td>
</tr>
<tr>
<td>2</td>
<td>Send first weekly response rate and helpline monitoring form to Acute Co-ordination Centre</td>
<td>12</td>
</tr>
<tr>
<td>3</td>
<td>Establish system for booking in questionnaires</td>
<td>16.5</td>
</tr>
<tr>
<td>3</td>
<td>Check your own trust's records again for any patient deaths</td>
<td>10.2</td>
</tr>
<tr>
<td>3 - 8</td>
<td>Stick labels on pre-packed numbered questionnaires and reminders supplied by approved contractor (if NOT using honorary contract)</td>
<td>16.4</td>
</tr>
<tr>
<td>3</td>
<td>Send out first questionnaires</td>
<td>16.4</td>
</tr>
<tr>
<td>3 - 14</td>
<td>Continue to respond to telephone enquiries</td>
<td>16.2</td>
</tr>
<tr>
<td>3 - 14</td>
<td>Log and process returned questionnaires</td>
<td>16.5</td>
</tr>
<tr>
<td>3 - 14</td>
<td>Enter data</td>
<td>17</td>
</tr>
<tr>
<td>6</td>
<td>Check your own trust's records again for any patient deaths</td>
<td>10.2</td>
</tr>
<tr>
<td>6</td>
<td>Send out first reminders to non-responders</td>
<td>16.6</td>
</tr>
<tr>
<td>6 - 7</td>
<td>Be prepared for a small peak in telephone calls as first reminders received</td>
<td>16.2</td>
</tr>
<tr>
<td>9</td>
<td>Check your own trust's records for any patient deaths</td>
<td>10.2</td>
</tr>
<tr>
<td>9</td>
<td>Send out second reminders to non-responders</td>
<td>16.6</td>
</tr>
<tr>
<td>13</td>
<td>Complete data entry</td>
<td>17</td>
</tr>
</tbody>
</table>
13 Check data for errors

14 Send data to Acute Co-ordination Centre (by 8th December 2006 at the latest)

14 Send two copies of the questionnaire used, all covering letters and a copy of the checklist to the Acute Co-ordination Centre (by 15th December 2006 at the latest)

14 Begin analysing trust's results and writing report

15 **Disseminate results to staff, patients and the public**

You must keep hard paper copies (or scanned images of all of the pages of the questionnaires, including the front page) of all questionnaires returned to you until 30th April 2007

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**Timetable for inpatient survey 2006**

<table>
<thead>
<tr>
<th>Activity</th>
<th>August</th>
<th>September</th>
<th>October</th>
<th>November</th>
<th>Dec</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Trust contacts</strong></td>
<td>W1</td>
<td>W2</td>
<td>W3</td>
<td>W4</td>
<td>W1</td>
</tr>
<tr>
<td>Notification date for trust to identify survey contacts to ACC</td>
<td>W2</td>
<td>W3</td>
<td>W4</td>
<td>W5</td>
<td>W1</td>
</tr>
<tr>
<td><strong>Publish guidance</strong></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Publish guidance to trusts and contractors</td>
<td></td>
<td>L -</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Approved contractor status</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date by which the ACC must be notified by, if a trust is to use an approved contractor</td>
<td>L</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Samples checking</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Submission of samples to ACC for checking</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>First weekly submission</strong></td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>First submission of outcome and helpline monitoring to ACC</td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>National survey</strong></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>National survey carried out over this period</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Data due</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Final data due</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
10 Compiling a list of patients

This section explains how to draw a sample of patients. This task will need to be carried out by a member of staff at the NHS Trust. 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 by the NHS Strategic Tracing Service (NSTS) to identify deceased patients.

Please follow the instructions below carefully and allocate sufficient work time to check the sample with NSTS before the first mailing and within the trust prior to each mailing.

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

10.1 Compile a list of eligible patients

1) Select the month of inpatient discharges in which your survey sample will end. You should start counting back from the last day of either June 2006 or July 2006 or August 2006. For consistency, please sample the same month as was sampled in the 2005 inpatient survey unless you have good reason to believe that this month was irregular in a way that would generate an unusual sample. If so, please choose the next most recent month.

2) Compile a list of 900 ** adult (aged 16 and over) inpatients consecutively discharged alive from your trust working back from 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 (ie 30th June 2006 OR 31st July 2006 OR 31st August 2006), you should count back through the list of patients discharged live from the trust, 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 include:

- ALL eligible adult patients, who have had at least one overnight stay (see Glossary) within the trust.

The list should exclude:

- deceased patients
- children or young persons aged under 16 years
- obstetrics/maternity service users (see Glossary)
- patients admitted for termination of pregnancy
- psychiatry patients (see Glossary)
- day cases
- private patients (non-NHS)
- current inpatients
- patients without a UK postal address (but do not exclude if addresses are incomplete but useable eg no postcode).

** The final sample size must be no greater than 850, but this allows for a safety margin of a few extra patients, once any deceased patients have been taken out of the sample.
10.2 Treatment Centres

Patients who stayed as an inpatient at a NHS treatment centres at the trust are eligible for inclusion in the sample for the 2006 inpatient survey, provided they meet criteria above. These patients should be flagged up by inserting a ‘1’ in the appropriate column on Table 1 – Sample Excel file of patient details.

10.3 Checks carried out by the trust

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

- **Deceased patients.** Check hospital records do not have a record of a patient’s death from a subsequent admission or visit to hospital.

  Checks for deceased patients

  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 upset 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 (NSTS) as well.

  The methodology for this survey requires three stages of checks for deceased patients before the first mailing is sent out. The checks are carried out sequentially by:

  1) the trust
  2) NSTS
  3) again by the trust (for patients who may have died in hospital after submission of the sample to NSTS).

  You are also advised to repeat this check before the second and third mailings, and to ensure that approved contractors are advised immediately if any patients in the sample die during the survey period.

- **Overnight stay.** Check that patients had at least one overnight stay in hospital. Patients are considered to have had an overnight stay if they were admitted as an inpatient and occupying a bed at midnight, eg patients who are admitted as an inpatient on Day 1 and discharged on Day 2 are considered to have had a single overnight stay regardless of their admission time or discharge time. Day cases and outpatients are not included in this survey.

- **Current inpatients.** Check that none of the patients are known to be current inpatients in your trust (or elsewhere, if possible).

- **Patient ages.** Check that all patients are aged 16 or over at the time of sampling.

- **Postal addresses.** Exclude any addresses that are outside the UK.

- **Incomplete information.** Check for any records with incomplete information on key fields (such as surname and address) and remove those patients. However, do not exclude anyone simply because you do not have a postcode for them. Only remove a patient if there is insufficient name or address information for the questionnaire to have a reasonable chance of being delivered. The more cases that are removed at this stage, the poorer the sample coverage and the greater the danger of bias.

- **Duplications.** Check that the same patient has not been included more than once.
• Obstetrics/maternity service user. Check that the list does not include maternity service users.
• Check again that none of the patients were admitted for a termination of pregnancy.
• Psychiatry patients. Check 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.

10.4 Create the sample file

An example of the spreadsheet you should complete has been included below. This is available to be downloaded from our site (www.NHSSurveys.org) is entitled “Sample construction spreadsheet”. The column headings will match to the validated spreadsheet for final submission of data produced by the Acute Co-ordination Centre and so it will be advantageous for you to use this spreadsheet.

This file has three purposes:

1) It will be used to keep a record of which patients have not returned questionnaires so that reminders can be sent to them.
2) It will be used to generate weekly response rates for your trust that must be forwarded to the Co-ordination Centre every Thursday from the 21st September 2006 until the closing date of the survey.
3) The anonymous data in this file (ie all the data except patient name and address information) will form part of the file that you will submit to the Acute Co-ordination Centre when the survey is completed.

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 admission | Month of admission | Year of Admission | Day of discharge | Month of discharge | Year of discharge | Length of Stay | Main Specialty on discharge | PCT of Residence | Treatment centre | Day of questionnaire being received | Month of questionnaire being received | Year of questionnaire being received | Outcome | Comments |
|-----------------------|---------|----------|---------|----------|----------|----------|---------------|--------|--------------|------------------|--------------------|------------------|------------------|-------------------|-----------------|----------------|-------------------------|------------------|-----------------|-------------------------------|---------------------|-------------------|----------|
| 1001                  | Mrs     | AM       | Abbot   | AB1      | 1YZ      | AB1 1YZ  | 1934          | 2      | 1            | 5 8 2006         | 11 8 2006          | 6 2006           | 100              | 5LS               | 0               | Inform ed that patient had died | 3               |                  |                     |                     |                  |                  |
| 1002                  | Mr      | EC       | Ahmed   | AB2      | 6XZ      | AB2 6XZ  | 1970          | 1      | 3            | 20 7 2006        | 12 8 2006          | 23 101 2006      | 101              | 5LT               | 1               | 22 10 2006                  | 1               |                  |                     |                     |                  |                  |
| 1849                  | Ms      | K        | Yoo     | AB4      | 7MX      | AB4 7MX  | 1950          | 2      | 5            | 17 6 2006        | 31 8 2006          | 75 300 2006      | 300              | 5LS               | 0               |                             |                  |                  |                     |                     |                  |                  |
| 1850                  | Ms      | F        | Young   | AB9      | 5ZX      | AB9 5ZX  | 1946          | 2      | 1            | 14 8 2006        | 31 8 2006          | 17 100 2006      | 100              | 5GT               | 1               | 6 11 2006                  | 1               |                  |                     |                     |                  |                  |
Important note about table 1

The headings of Table 1 are in three different colours:

**Bold black** headings: these columns contain information on patients’ names, addresses and comments that may allow them to be identified. This information should be deleted from all files sent to the Acute Co-ordination Centre.

**Red italic** headings: these columns should be completed during the sampling phase and submitted to the Acute Co-ordination Centre prior to mailing for final inspection (see Section 11) and at the conclusion of the survey.

**Green italic** headings: these columns should be completed when the patient responds to the survey, either by returning a completed questionnaire, or the trust is notified the patient will not be participating (patient deceased, moved address, too ill, or called to opt out).

The following information is compiled using hospital records:

- **Title** (Mr, Mrs, Ms, etc.)
- **Initials** (or First name)
- **Surname**
- **Address Fields** ††
- **Postcode**

**Note**

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

- **The Year of Birth** should be included in the form of NNNN.
- **Gender** should be coded as 1 = male and 2 = female.
- **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 derived from the standard categories introduced by the NHS Information Authority from 1st April 2001, but if your trust is not using these categories, the data will need to be re-coded to these numeric codes.

**Note**

If the ethnic group is unknown, this cell should be left blank. Do NOT automatically code unknown ethnic groups as 6 – this code is reserved for patients whose ethnic group is known, but does not fall into one of the categories labelled 1-5 above.

- **Day** of the month of admission (1 or 2 digits; eg 7 or 26)*
- **Month** of admission (1 or 2 digits; eg 9 or 10)*
- **Year** of admission (4 digits; eg 2006)*
- **Day** of the month of discharge (1 or 2 digits; eg 2 or 30)*
- **Month** of discharge (1 or 2 digits; eg 9 or 10)*

†† The address should be held as separate fields (eg street, area, town, and county), consistent with the address format required by the NSTS.

* Date fields must be supplied in separate columns (eg date, month, and year).
• **Year** of discharge (4 digits; eg 2006) *

• **Length of Stay** (Units = Days)**‡‡

• Main Specialty on Discharge is recorded in the form NNN as outlined in the Updated National Specialty List which was implemented on the 1 April 2004. See Supporting Information: Main Specialty And Treatment Function Codes.

• **PCT of Residence** should be coded using the first three characters of the PCT character codes (maintained by the National Administrative Codes Service). They provide postcode files which link postcodes to the PCTs.

• **Treatment Centre Admission** should be coded as ‘1’ for patients who spent any part of their inpatient stay at an NHS treatment centre within the trust, and coded as ‘0’ if they did not.

Additional information should also be entered on this spreadsheet. The details of this information are discussed below:

1) **Patient record number.** This field will be a series of consecutive whole numbers (for example, 1001 through to 1850). 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 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.

2) **Day of questionnaire being received.** This can only be completed if and when a questionnaire is received by the trust or approved contractor. It should be a one or two digit numerical response eg N or NN, not a date format eg 12/07/74.

3) **Month of questionnaire being received.** This can only be completed if and when a questionnaire is received by the trusts or approved contractor. It should be a one or two digit numerical response, not a date format.

4) **Year of questionnaire being received.** This can only be completed if and when a questionnaire is received by the trusts or approved contractor. It should be a four digit numerical response, not a date format.

5) 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.

   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).

   The outcome column is left blank at first if the survey has not been returned (on table 1 you can see that Ms Yoo has not yet returned her questionnaire).

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

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**‡‡** Calculate this by subtracting the admission date (day/month/year) from the discharge date (day/month/year). For example, if discharge date = 15/7/2006 and admission date = 14/7/2006, the Length of Stay = 1. Do not use any other type of unit to calculate Length of Stay (ie do not use hours/minutes/seconds). All patients in the sample should have a Length of Stay greater than or equal to 1 day.

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10.5 Distribution of patient ages

You should check that patients of all ages are included in your sample, especially for those aged 16, 17 or 18 years or those over 75 years. We have found these age groups are the most likely to be excluded due to poor sampling. It is possible there may not be any young adults or very old adults in your sample, but this should be confirmed by checking your original sample (before exclusion criteria were applied) and your sampling techniques.

Check that your sampled patients' ages cover the full range of expected ages. Ideally, you should do this by checking the distribution of ages on a histogram (See Table 2). For most trusts the histogram should start out with a broad base (representing substantial numbers of young adults), then increase for those aged around 60 years (baby-boomers), before entering a slow decline to reflect fewer people at extreme old age.

**Table 2 - Age Histogram for Inpatient 2005 survey**

<table>
<thead>
<tr>
<th>Year of birth</th>
<th>Number of responders</th>
</tr>
</thead>
<tbody>
<tr>
<td>1908-1911</td>
<td>190</td>
</tr>
<tr>
<td>1914-1917</td>
<td>190</td>
</tr>
<tr>
<td>1920-1923</td>
<td>190</td>
</tr>
<tr>
<td>1926-1929</td>
<td>193</td>
</tr>
<tr>
<td>1932-1935</td>
<td>193</td>
</tr>
<tr>
<td>1938-1941</td>
<td>193</td>
</tr>
<tr>
<td>1944-1947</td>
<td>194</td>
</tr>
<tr>
<td>1950-1953</td>
<td>195</td>
</tr>
<tr>
<td>1956-1959</td>
<td>196</td>
</tr>
<tr>
<td>1962-1965</td>
<td>197</td>
</tr>
<tr>
<td>1968-1971</td>
<td>191</td>
</tr>
<tr>
<td>1974-1977</td>
<td>197</td>
</tr>
<tr>
<td>1980-1983</td>
<td>194</td>
</tr>
<tr>
<td>1986-1989</td>
<td>198</td>
</tr>
</tbody>
</table>

10.6 Distribution of patient gender

With the exception of hospitals specialising in one gender, your sample will probably have similar proportions of men and women. You should check each of these genders are included and that you can explain if the sample is skewed toward male or female patients.

10.7 Submit the patient list to the NHS Strategic Tracing Service (NSTS)

Before sending out the questionnaires, the list of patients must be checked for any deceased patients by the NHS Strategic Tracing Service (NSTS). NSTS will return your sample file with deceased patients clearly identified.

The NSTS contact details are as follows:

Help desk telephone number: 0121 788 4001
The time required to carry out the checks depends partly on the compatibility of the patient list you submit to the NSTS with their system requirements. NSTS tracing takes between 12 to 48 hours if submitted correctly. To avoid any delay, check carefully that your list is in the correct format for NSTS. The Caldicott Guardian for your trust will be able to provide you with details on how to carry out a “batch trace” for deceased patients.

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

- Specific details are required by the NHS Strategic Tracing Service (NSTS). These should not be submitted to the Acute Co-ordination Centre. One of these is the patient’s NHS number. The NHS number can assist more accurate tracing, especially if addresses are incomplete. It is advisable to liaise with the registered NSTS batch trace user to ensure that you have extracted all the required fields.

For further help on batch tracing for patients, please view the document:

http://www.connectingforhealth.nhs.uk/nsts/docs/trace_out.pdf

Note

Please be aware that tracing services are not foolproof 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.

10.8 When the patient file is returned from the NSTS

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

If you have more than 850 patients remaining on your list

When your patient list is returned by NSTS, and you have removed all deceased patients, there should still be more than 850 patients in the list. You will need to remove the least recent patients from your sample so that only the 850 most recent patients remain.

If you have fewer than 850 patients remaining on your list

If your patient list has fewer than 850 patients after deceased patients have been removed, you MUST contact the Acute Co-ordination Centre. If possible, the next most recently discharged patients after the sample will need to be added to create a sample of 850 patients, although these must also be checked by NSTS.
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 two 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 Acute Co-ordination Centre will only be able to accept responses from the patients in your list of 850 that have been correctly sampled and mailed.

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

10.9 Sharing the patient sample file with an approved contractor

If you are working with an approved contractor and have an honorary contract, the full sample information and the name and address information should be sent to those contractor staff covered by the honorary contract. If you are working with an approved 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 – Sample Excel file of patient details, 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 patient deaths, etc.

10.10 Creating the mailing and response spreadsheets

At this point, you should generate two copies of your sample file and name them "<NHStrustName>_Inpatient2006.xls" and "Inpatient 2006 mailing spreadsheet". The following changes should be made:

- <NHStrustName>_Inpatient2006.xls: delete all name, address and comment columns ie all columns in bold black in Table 1 – Sample Excel file of patient details by the Acute Co-ordination Centre (on our website www.NHSSurveys.org), which has all the required columns for the sample information, as well as columns for the response data from returned questionnaires. Only this “anonymised” version can be used to record patient responses. It is this version of the spreadsheet that must be submitted to the Acute Co-ordination Centre.
- Inpatient 2006 mailing spreadsheet: this spreadsheet is used for mailing purposes. It is essential that the “Outcome” column (about whether patients have responded, or why they have not responded) is kept accurate and up-to-date. Reminders can then be sent to patients who have not yet responded.

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.

10.11 Increasing sample size beyond minimum requirement

Your trust may wish to use the acute patient survey programme as an opportunity to gather data in addition to that required by the Healthcare Commission. One way to do this is to increase the number of patients you sample, and ensuring that you target sufficient numbers from each of the units you want to compare so that you can get enough responses to make comparisons. However, before you decide to do this, there are some important points to consider:

- The core sample for the 2006 inpatient survey must be drawn as specified in this guide. It is essential that any additional sample drawn can be easily distinguished from the core sample, and that it is drawn in such a way as to not interfere with selection of the core sample.
• Small, limited surveys are easier for in-house staff to handle than large surveys. You may wish to consider keeping the two things separate by doing the large acute patient survey on its own (either in-house or with an approved contractor) and then following it up with smaller, targeted in-house surveys.

To summarise

If you do 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 must only send the Acute Co-ordination Centre data for the 850 patients sampled according to these guidelines, and these patients must be those discharged most recently. Any additional patients selected to increase your survey beyond the minimum requirements of the 2006 inpatient survey must have been discharged earlier than the core sample.
11 Final sampling inspection by the Acute Co-ordination Centre

Trust data should still be checked for errors and received back from NSTS before being forwarded to the Acute Co-ordination Centre. An anonymised sample file§§ must be submitted to the Acute Co-ordination Centre prior to the first mailing. This is to allow us to make final quality control checks. All columns in red italics must be submitted, but name, address and postcode details must be removed.

If you are using an approved contractor, the sample should be checked as normal by the trust and by NSTS before being submitted to the contractor. We strongly recommend the contractor carries out the same high standard of checks as in previous years, but will then submit the file to the Acute Co-ordination Centre. The Acute Co-ordination Centre will address any issues arising from these final checks to the approved contractor.

The Acute Co-ordination Centre will be checking for extraordinary errors. These are more visible when viewing data from many trusts at one time. For this reason, samples will be checked as collated files. Files that arrive Monday to Thursday (inclusive) will be returned to the trusts or approved contractors they were received from on the following Monday afternoon. A timetable has been included below:

<table>
<thead>
<tr>
<th>Date sample received</th>
<th>Date sample returned</th>
</tr>
</thead>
<tbody>
<tr>
<td>18th-22nd September 2006</td>
<td>25th September 2006</td>
</tr>
<tr>
<td>25th-29th September 2006</td>
<td>2nd October 2006</td>
</tr>
</tbody>
</table>

Samples must reach the Acute Co-ordination Centre by 28/09/06 or your trust will not have enough time to correct any problems in the sample and complete the survey with an acceptable response rate.

§§ By removing the patients’ names, addresses and postcodes.
12 Weekly monitoring

The Acute Co-ordination Centre requires weekly submissions of outcome data and helpline calls for each trust taking part in the 2006 inpatient survey. First submission of data must be made on Thursday 21st September ***, and every Thursday thereafter until the final date of submission. An Excel spreadsheet is available on www.NHSSurveys.org which should be used to return this information to the ACC. This information should be emailed to the ACC (acute.data@pickereurope.ac.uk) by midday every Thursday throughout the survey.

Weekly submissions only apply to the core sample of patients

12.1 Response rate

The information submitted should contain the following data:

- The total number of patients in your sample ie the total number of all those included in the first mailing,
- The number of patients in each outcome field (see Section 5)

This will allow the Acute Co-ordination Centre to monitor progress at a trust level and to identify trusts that may need assistance.

12.2 Helpline monitoring

The information you submit should contain the following data for each trust:

- The total number of calls received by the helpline for this survey
- The total number of calls that led to completion of the questionnaire using the helpline
- The total number of calls seeking assistance with language and translation
- The total number of calls that led to completion of the questionnaire using translation services

This information allows the Acute Co-ordination Centre to identify areas of concern to patients and to improve future surveys.

*** This submission must be made regardless of whether mailing has commenced.
13 Publicising the survey

The following measures will help to increase response rates and reduce the number of questions and any complaints received about a survey:

- Patients can be expected to ask doctors, nurses, patient liaison officers, or the Chief Executive's office about the survey, even when your covering letters give contact details for the survey manager(s) and the dedicated helpline. Notify front line staff and executive offices that a survey is being conducted, and give them the name and number of a contact person. Survey manager(s) should be prepared to respond to these calls quickly.
- Heighten awareness of the survey and the importance the trust places on patient feedback through posters in the hospital. Also, it is sometimes a good idea to send a press release to the local media to gain publicity before the survey takes place.
- Template staff briefings and information for use in press releases can be downloaded from the NHSSurveys website.
14 The core questions and question bank

Each trust must include in their survey at least the 75 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 to create an enhanced questionnaire. These questions will be automatically inserted into the appropriate places within the core questionnaire, and the document will then be generated in PDF format, ready for printing.

In summary, there are two options for carrying out the NHS inpatient survey:

1) The core inpatient questionnaire, which comprises 75 core questions.
2) The enhanced questionnaire, which includes the 75 core questions, with an additional selection from the bank of validated questions‡‡‡.

14.1 The core questionnaire

The core questionnaire consists of 75 questions on 12 pages. These questions cover the issues that have been found to be most important to patients and must be included in your survey. The front page of the questionnaire explains the purpose of the survey and gives instructions on how to fill it in. In the pages that follow, the survey questions are divided into sections that broadly follow the patient's experience.

14.2 Using the question bank

The core questionnaire covers all the compulsory questions you need to ask to comply with the NHS national patient 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 the 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 de-selected from the question bank. The questions with no tick boxes (just bullet points) cannot be de-selected because they are compulsory core questions, and they must be included.

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.

††† This programme requires you to create a log-in and password for access. This is solely for the purpose of saving your extended questionnaire.

‡‡‡ It is not advisable to use ALL of the optional questions in the question bank, as this would require an 18-page questionnaire.
15 Materials

15.1 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 onto 12 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 with 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 total number of questionnaires required. So, if the number of first mailing questionnaires you intend to send out is 850, then you might want to print 1.7 x 850, or approximately 1,500 copies.

15.2 Trust headed paper

You will need headed paper from your trust for covering letters for the first and third mailing. A reminder letter is used for the second mailing. Therefore, depending on your response to the initial mailings, you will 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.

15.3 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
- Covering letters using the trust’s letterhead
- Multi-language helpline sheet (recommended).
15.4   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 you will need to send first reminders to around 55-75% of the original patient sample. The following items are needed:

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

15.5   Third mailing (second reminder)

The second reminder should replicate the first mailing, and you will need to send this 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
- Reminder letters
- Multi-language helpline sheet (if used in first mailing).
16 Implementing the survey - practicalities

16.1 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

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

16.2 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.

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.

Below are some questions and comments commonly asked by patients and some advice on how they can be handled:

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 there is a good chance that the responses 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 may 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. These patients should be logged as outcome = three (patient deceased).

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, such as a family member, fill in a form on their behalf. It is also strongly recommended that you offer access to a telephone interpretation service, where the questionnaire can be filled in over the telephone. A multi-language sheet template in the twenty most commonly spoken languages in England is available on our website, and trusts or contractors can make use of this by inserting the appropriate number for their helpline and/or translation service.

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 taking part in the survey is voluntary, and that the patient’s care will not be affected in any way if they do not respond. 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 (patient record 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. These patients should be logged as outcome = four (opt out).

Making a record of the calls

It is important 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 produced for completion by those taking the calls. The relevant details of each call can be recorded so that survey organisers can monitor any problems and remove patients who wish to be excluded from the mailing list.

We are also asking for weekly submissions of helpline use for each trust to the Acute Co-ordination Centre. This is discussed in detail in Section 12.2.

16.3 Covering letters

The standard covering letter is available in Microsoft Word format on the inpatients section of the NHSSurveys website for you to download and add your own trust’s details. This letter has been given ethical approval for use in the NHS Inpatient Survey and changes are not permissible. It should be printed on the trust's letterhead paper. Two paper copies of the letter you use must be sent to the Acute Co-ordination Centre when you submit your data at the end of the survey.

16.4 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 number on the front of the questionnaire. The label should not include any other information except the patients’ names, address and postcode details, and the patient record 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 must match (or correspond to) the number on the address label and the number on the list of patient details.
2) A covering letter.
3) The multi-language helpline sheet (recommended)
4) A large envelope, labelled with the FREEPOST address on it.
5) 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. The Royal Mail has recently published revised mailing prices; previous quotes for mailing may be out-of-date.

**Approved contractors – honorary contract**

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

**Approved contractors – no honorary contract**

If an approved contractor is carrying out most of the work but not operating under an approved contract, 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.

**16.5 Booking in questionnaires**

When questionnaires are received, match up the patient record numbers against the list of patients, so that you can record (in the outcome column) 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 all of the pages of the questionnaires, including the front page) of any questionnaires that are returned to you until 30th April 2007, but please do not send these to the Acute Co-ordination 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 to the trust 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.

16.6 Sending out reminders

For results to be representative, it is essential to get a good response rate. To achieve this, you must send out two reminders to non-responders. Remember, it is essential that you send out both reminders, even if you already have achieved a 60% response rate.

Depending on the time that has elapsed since you first checked your patient list for deaths, it might be necessary to send your list back to the tracing service for a further check before you send out reminders.

Approved contractors

When reminders are due to be sent out, approved 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 those carrying out the mailing can match these with their patient list and put on appropriate address labels.

First reminders

The first reminder should be sent to patients who have not responded after one to two weeks. The standard first reminder is available in Microsoft Word format on the NHSSurveys website for you to download. It can be printed on A5. It has been given ethical approval so no changes are permitted. Two paper copies of the reminder letter you use must be sent to the Acute Co-ordination Centre when you submit your data at the end of the survey.

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 must match (or correspond to) the number on the address label and the number on the list of patient details.
2) A covering letter.
3) A multi-language helpline sheet (if used in first mailing)
4) A large envelope, labelled with the FREEPOST address on it.

The standard second reminder letter is available in Microsoft Word format on the NHSSurveys website for you to download and add your trust’s details. It has been given ethical approval so no changes are permitted. Two paper copies of the second reminder letter you use must be sent to the Acute Co-ordination Centre when you submit your data at the end of the survey.

Remember that you should check your trust’s own records for deaths before sending out reminders.
17  Entering data

The data must be submitted to the Acute Co-ordination Centre in the appropriate format by the deadline of 8th December 2006. If an approved 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 Acute Co-ordination Centre in the correct format and supply the trust with an anonymised data set (see Section 6 on data protection issues).

17.1 Entering and coding data from the core questionnaire

The data should be entered into the pre-designed Excel file, which can be found in the inpatient 2006 survey section of the NHSSurveys website.

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 full stop (.).
- If two boxes are ticked (where only one should be ticked), the response should be left blank or coded as a full stop (.).
- When saving this file to submit data to the Acute Co-ordination Centre, please save only the first sheet as a worksheet, rather than saving the whole file as a workbook.

17.2 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.

17.3 Adapting the data file for sending data to Acute Co-ordination Centre

You will need to send the data from only the 75 compulsory core inpatient survey questions to the Acute Co-ordination Centre. To do this, you will need to transfer those columns of data that cover the responses to those 75 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 inpatient questionnaire. They also include the wordings of the 75 core inpatient questions so that you can match them up. It is essential that you check carefully that the columns of data you select from any larger data set correspond to the 75 core inpatient survey questions.

§§§ 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 full stop (.)

Adult Inpatient Guidance 2006.
Picker Institute Europe. All rights reserved. [JASON BOYD/SD/24 AUGUST 2006/V1]
17.4 Checking the data for errors

For the 2006 national inpatient survey, trusts and contractors are required to submit raw ('uncleaned') data to the Acute Coordination Centre. For clarification, raw data is created by the following:

1) All responses should be entered into the dataset, regardless of whether or not the respondent was meant to respond to the question (eg where patients answer questions that they have been directed to skip past, these responses should still be entered).
2) Where a respondent has ticked more than one response category on a question, this should be set to missing in the data.
3) Where a respondent has crossed out a response, this should not be entered in the data. Where a respondent has crossed out a response and instead ticked a second response option, this second choice should be entered into the data.
4) Where a respondent has given their response inconsistently with the formatting of the questionnaire but where their intended response is nonetheless unambiguous on inspection of the completed questionnaire, then the respondent’s intended response should be entered. For example, where a patient has written their date of birth in the boxes for Q70, but written their year of birth in at the side of this, then the respondent’s year of birth should be entered.
5) For the year of birth question, unrealistic responses should still be entered except following rule 4) above). For example, if a respondent enters ‘2006’ in the year of birth box, this should still be entered unless the respondent has unambiguously indicated their actual year of birth to the side.
6) Once the data has been entered, no responses should be removed or changed in any way except where responses are known to have been entered incorrectly or where inspection of the questionnaire indicates that the patient’s intended response has not been captured. This includes ‘out-of-range’ responses, which must not be automatically removed from the dataset. Responses in the dataset should only be changed before submission to the Acute Coordination Centre where they are found to have been entered inconsistently with the respondent’s intended response.

17.5 Submitting data to the Acute Co-ordination Centre

The data from the core questions of the 2006 inpatient survey must be supplied to the Acute Coordination Centre as one anonymised Excel file that includes information about the patient sample and responses. To comply with the Data Protection Act, name and address details must not be sent to the Acute Co-ordination Centre.

Required file format

Please submit the file to the following specifications:

- Use Microsoft Excel Worksheet (not Workbook). Any version of Excel is acceptable.
- The file name must be in the form <NHTrustName>_Inpatient2006.xls.
- Use one row of data for each patient in the sample.
- Use one column of data for each item of patient information or response.
- Missing data should be left blank or coded as a full stop (.)

**** Data may be missing for a number of reasons. The patient may have skipped a question or a set of questions by following instructions; a patient may have not answered for some other reason. However, all missing data should be left blank or coded as a full stop (.), regardless of the reason for the omission.

-----------------------------------------------------------------------------------
Table 3 shows the information that must be provided for each of the 850 patients in the original sample.

### Table 3 - Data fields to be included in file submitted to Acute Co-ordination Centre

<table>
<thead>
<tr>
<th>Field</th>
<th>Format</th>
<th>Data codes</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient record number</td>
<td>N, NN, NNN or NNNNN</td>
<td></td>
<td>The unique serial number allocated to each patient by the trust or approved contractor administering the survey.</td>
</tr>
<tr>
<td>Year of birth</td>
<td>NNNNN</td>
<td></td>
<td>Format this simply as a number, not in date format.</td>
</tr>
<tr>
<td>Gender</td>
<td>N</td>
<td>1 = male, 2 = female</td>
<td>If gender is not known or unspecified, this field should be left blank or coded as a full stop (.)</td>
</tr>
<tr>
<td>Ethnic Group</td>
<td>N</td>
<td>1 = White, 2 = Mixed, 3 = Asian or Asian British, 4 = Black or Black British, 5 = Chinese, 6 = Other ethnic group</td>
<td>Ethnic Group should be included if the information is available. Do NOT automatically code unknown ethnic groups as 6 – this group is only for those patients who are known not to belong to any of the other 5 named groups.</td>
</tr>
<tr>
<td>Day of admission</td>
<td>N or NN</td>
<td></td>
<td>For example, if the patient was admitted on July 15th 2006, this column should read 15.</td>
</tr>
<tr>
<td>Month of admission</td>
<td>N or NN</td>
<td></td>
<td>For example, if the patient was admitted on July 15th 2006, this column should read 7.</td>
</tr>
<tr>
<td>Year of admission</td>
<td>NNNNN</td>
<td></td>
<td>For example, if the patient was admitted on July 15th 2006, this column should read 2006.</td>
</tr>
<tr>
<td>Day of discharge</td>
<td>N or NN</td>
<td></td>
<td>For example, if the patient was discharged on July 20th 2006, this column should read 20.</td>
</tr>
<tr>
<td>Month of discharge</td>
<td>N or NN</td>
<td></td>
<td>For example, if the patient was discharged on July 20th 2006, this column should read 7.</td>
</tr>
<tr>
<td>Year of discharge</td>
<td>NNNNN</td>
<td></td>
<td>For example, if the patient was discharged on July 20th 2006, this column should read 2006.</td>
</tr>
<tr>
<td>Length of Stay</td>
<td>N to NNNNN</td>
<td></td>
<td>For example, if the admission date was 15/7/2006 and the discharge date was 16/7/2006, the Length of Stay = 1.</td>
</tr>
<tr>
<td>Main Specialty of Discharge</td>
<td>NNN</td>
<td>Use the codes as outlined in the Updated National Specialty List which was implemented on the 1st April 2004</td>
<td>Only supply the ‘Main specialty’ for each patient on their DISCHARGE.</td>
</tr>
<tr>
<td>PCT of Residence</td>
<td>NNN</td>
<td>Use the character codes maintained by the National Administrative Codes Service</td>
<td>Only use the FIRST three characters of the PCT of residence code</td>
</tr>
<tr>
<td>Treatment centre admission</td>
<td>N (0 or 1)</td>
<td></td>
<td>This flags whether the patient spent time in a NHS treatment centre at the trust</td>
</tr>
<tr>
<td>Field</td>
<td>Format</td>
<td>Data codes</td>
<td>Comments</td>
</tr>
<tr>
<td>--------------------------</td>
<td>--------</td>
<td>-----------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Day of receiving</td>
<td>N or</td>
<td>This is the day you received a returned questionnaire from a respondent, or</td>
<td>For example, if the questionnaire was received on July 15th 2006, this column should read 15.</td>
</tr>
<tr>
<td>questionnaire</td>
<td>NN</td>
<td>are notified that the patient will not be participating in the survey (patient deceased, moved address, too ill, or called to opt out)</td>
<td></td>
</tr>
<tr>
<td>Month of receiving</td>
<td>N or</td>
<td>This is the month you received a returned questionnaire from a respondent,</td>
<td>For example, if the questionnaire was received on July 15th 2006, this column should read 15.</td>
</tr>
<tr>
<td>questionnaire</td>
<td>NN</td>
<td>or are notified that the patient will not be participating in the survey (patient deceased, moved address, too ill, or called to opt out)</td>
<td></td>
</tr>
<tr>
<td>Year of receiving</td>
<td>NNNN</td>
<td>This is the year you received a returned questionnaire from a respondent, or</td>
<td>For example, if the questionnaire was received on July 15th 2006, this column should read 15.</td>
</tr>
<tr>
<td>questionnaire</td>
<td></td>
<td>are notified that the patient will not be participating in the survey (patient deceased, moved address, too ill, or called to opt out)</td>
<td></td>
</tr>
<tr>
<td>Outcome of sending</td>
<td>N</td>
<td>1 = Returned useable questionnaire</td>
<td>Remember to fill in all the blank cells with 6s when the survey is complete.</td>
</tr>
<tr>
<td>questionnaire</td>
<td></td>
<td>2 = Returned undelivered by the mail service or patient moved house</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>3 = Patient died</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>4 = Patient reported too ill to complete questionnaire, opted out or</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>returned blank questionnaire</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>5 = Patient was not eligible to fill in questionnaire</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>6 = questionnaire not returned (reason not known)</td>
<td></td>
</tr>
<tr>
<td>Responses to each of</td>
<td>N or</td>
<td>Each column must be clearly headed with the core questionnaire question</td>
<td></td>
</tr>
<tr>
<td>the 75 core questions</td>
<td>NN or</td>
<td>number. Data should be coded using the numbers next to the response boxes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>NNNN</td>
<td>on the printed surveys. There is no need to send the comments to the</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Acute Co-ordination Centre.</td>
<td></td>
</tr>
</tbody>
</table>

_N.B._ To comply with the Data Protection Act, name and address details must not be sent to the Acute Co-ordination Centre.
Table 4 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 4 – Example of data file to be submitted to Acute Co-ordination Centre

<table>
<thead>
<tr>
<th>Patient Sample Information</th>
<th>Patient Response Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient record number</td>
<td>Outcome</td>
</tr>
<tr>
<td>Year of birth</td>
<td>Q1</td>
</tr>
<tr>
<td>Gender</td>
<td>Q2</td>
</tr>
<tr>
<td>Ethnic Group</td>
<td>Q3</td>
</tr>
<tr>
<td>Day of admission</td>
<td>Q4</td>
</tr>
<tr>
<td>Month of admission</td>
<td>Q5</td>
</tr>
<tr>
<td>Year of discharge</td>
<td>Q6</td>
</tr>
<tr>
<td>Month of discharge</td>
<td>Q7</td>
</tr>
<tr>
<td>Year of discharge</td>
<td>Q8</td>
</tr>
<tr>
<td>Length of Stay</td>
<td>Q9</td>
</tr>
<tr>
<td>Main Specialty on discharge</td>
<td>Q10</td>
</tr>
<tr>
<td>PCT of Residence</td>
<td>Q11</td>
</tr>
<tr>
<td>Treatment centre</td>
<td>Q12</td>
</tr>
<tr>
<td>Day of receiving questionnaire</td>
<td>Q13</td>
</tr>
<tr>
<td>Month of receiving questionnaire</td>
<td>Q14</td>
</tr>
<tr>
<td>Year of receiving questionnaire</td>
<td>Q15</td>
</tr>
</tbody>
</table>

You should not send any of the patients’ written comments to the Acute Co-ordination Centre.
Additional information required

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

- **Contact details** (telephone numbers and e-mail addresses) of at least two members of trust staff (usually the main and secondary contacts) who will be available to answer any queries about the data
- Two blank **paper copies** of the questionnaires, the covering letters and the reminder letters you used
- A completed copy of the **checklist** (See Section 17.6 - Checklist).

Delivery

Hard copy documents should be posted to the address below. Data may be sent on floppy disc or by e-mail:

Postal address:

Inpatient Survey 2006  
Acute Co-ordination Centre for NHS Patient Survey Programme  
Picker Institute Europe  
King’s Mead House  
Oxpens Road  
Oxford  
OX1 1RX

E-mail: acute.data@pickereurope.ac.uk

Deadline for submission

The data must be supplied by 8th December 2006.
17.6 Checklist

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

It is essential that these checks are carried out thoroughly. The Acute Co-ordination 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 the Healthcare Commission in your trust’s performance assessment and your trust’s scores will be set to a minimum value. We cannot accept re-submissions of data after the deadline.

<table>
<thead>
<tr>
<th>Check</th>
<th>Done?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Check that your <strong>file name</strong> follows the naming convention:</td>
<td></td>
</tr>
<tr>
<td>&lt;NHStrustName&gt;_Inpatient2006.xls)</td>
<td></td>
</tr>
<tr>
<td>2) Check that you have saved the data sheet only as an Excel <strong>worksheet</strong>, rather than a workbook. (The frequency and percentage counts on the other pages of the workbook on the website are intended for your use only)</td>
<td></td>
</tr>
<tr>
<td>3) Check that you have included data columns for <strong>all 75 core questions</strong></td>
<td></td>
</tr>
<tr>
<td>4) Check that you have <strong>not</strong> included any columns of optional questions</td>
<td></td>
</tr>
<tr>
<td>5) Check that all <strong>data are correct</strong>, and that all values are in range</td>
<td></td>
</tr>
<tr>
<td>6) Send data only for the <strong>850 patients</strong> consecutively discharged from your trust in the chosen month</td>
<td></td>
</tr>
<tr>
<td>7) Check that all the data are in <strong>numeric format</strong> only</td>
<td></td>
</tr>
<tr>
<td>8) Check that you have completed the columns for the day, month and year you received the questionnaire back from patients</td>
<td></td>
</tr>
<tr>
<td>9) To comply with Data Protection regulations, any <strong>patient name and address details</strong> must be removed before the file is sent to the Acute Co-ordination Centre</td>
<td></td>
</tr>
<tr>
<td>10) Remove any <strong>passwords</strong></td>
<td></td>
</tr>
<tr>
<td>11) Include <strong>two paper copies</strong> of the questionnaire you used</td>
<td></td>
</tr>
<tr>
<td>12) Include <strong>two paper copies</strong> of the covering letters you used for the first, the second and third mailing.</td>
<td></td>
</tr>
<tr>
<td>13) Include <strong>telephone and e-mail contact details of two people</strong> who will be available to respond to any queries about the data</td>
<td></td>
</tr>
<tr>
<td>14) Check that you have <strong>not</strong> included any columns of optional questions</td>
<td></td>
</tr>
<tr>
<td>15) <strong>Check again</strong> that all data are correct, and that all values are in range!</td>
<td></td>
</tr>
</tbody>
</table>
18 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 examination of the frequency of responses to each question and some cross-tabulation of responses against demographic and other information.

18.1 Using the NHSSurveys website to look at your results

Once you have entered the data from the core questions into the Excel file on the website (the Data Entry Spreadsheet), the counts and percentages of responses to each of the 75 core questions are automatically computed and displayed on the other sheets of the Excel workbook, which correspond to sections of the inpatient core questionnaire (excluding the “Other Comments” section). 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 full stop (.).

18.2 Suggestions on data analysis

The following suggestions may help you 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 on where improvements are needed is to analyse responses in terms of 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, as also 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 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 questions and presenting findings in a way that is comprehensive, logical and not overwhelming is a significant challenge. To make the data more compelling for others, and to speed up the analysis, we suggest:

- Linking questions that cover similar topics or processes
- Combining several questions into a single composite measure (by averaging responses, for example)

Use statistical tests to make comparisons and subgroup analyses

Statistical tests can be used to examine relationships and associations between groups (for example age, sex or ethnic 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 responses). 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 provides 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.
19 Reporting results

19.1 Prioritising your findings

Patient surveys can raise many compelling and important issues. To help you decide which issues to focus on first, you may like to consider the following suggestions:

Rank results 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.

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 Healthcare Commission and NHSSurveys website to find out where your trust performs better or worse than other trusts.

Compare results within your organisation

Comparisons within organisations can facilitate networking among units or departments and the sharing of information about effective practices. Internal ‘competitiveness’ may also fuel improvement efforts.

Compare results over time

Investigating trends in survey results over time is another powerful analytical tool for prioritising areas for improvement. Analysis of trends allows you to focus on correcting aspects of performance that are slipping, although you should confirm any apparent changes between years are statistically significant.

Comparison with predefined goals

Another way to identify 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

Correlating patient responses to specific questions with responses to the question about overall quality of care can help focus attention on issues that are important for patients.
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. Regression analysis is also more complex but in essence, it allows for a more level 'playing field'. There are limits to a univariate (crude) analysis and so regression analysis is an attractive option.

Ease of action

Many organisations focus initially on the issues that are easiest to improve. 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.

19.2 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:

Tailor the document 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 separate resource booklet or data disks/CD-ROMs with full details may be important if staff or researchers have questions.

Use graphics

- Data that are displayed visually can be 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 visual elements can 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 sections.
- Highlight the most important items - for example, use bold type.
20 Using results for quality improvement

Arguably the most important aspect of the survey process is making use of the results to bring about improvements. It is essential that this patient 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.

20.1 Prepare in advance

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

- We recommend the survey lead / team take responsibility for developing a dissemination strategy to inform all of the relevant stakeholders about the survey findings
- Publicise the survey before it happens. Engaging staff from the start will help to ensure their support later on with any improvement initiatives. Involving the local media and informing the public may encourage a good response rate from patients

20.2 Dissemination of survey results

Engage key stakeholders

By communicating your survey results to key stakeholders you will help to ensure they are used effectively and not forgotten. Consider the following groups:

- Staff throughout the trust as they will be responsible for tackling any problems identified by patients.
- Board members as they are involved in prioritising areas for improvement and shaping action plans. Their support is often crucial for the successful implementation of change.
- Patients have taken time to report their experiences so they it is important they are informed of the results via local meetings, newsletters and articles in the local press.
- Patient groups with special interest in the trust who may have a key role to play in initiating discussions with the board about priorities for improvement and be keen to monitor progress as it occurs.
- When reporting the results it is a good idea to also 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

Consider how to share the survey results in training sessions, staff and public meetings, employee newsletters, executive communications, process improvement teams, patient care conferences, and other communications channels. You may wish to consider the following:

- Determine whether information should be shared initially with only senior-level people, or whether (and when) it should be spread further afield
- Make presentations to your trust board and to as many groups of staff as possible, each tailored appropriately for the audience
- Organise an 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
• Publish results in your trust newsletter along with details of improvement plans

Promote understanding

To assist others in understanding the results, we recommend the following:

• Present results in user-friendly formats. Remember not everyone will be an expert in reading graphs and deciphering data
• 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

20.3 Identify key "change agents"

The people who can motivate others to bring about change and who hold the 'keys' to improvement in the organisation are not necessarily the most senior people. Identify these individuals and involve them as "change agents" early in the survey process.

20.4 Develop an action plan

Having used your survey results to identify areas for improvement, we recommend you work with staff and patients to prioritise 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. You can also 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.
20.5 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 focus your improvement effort. It can be time-consuming and expensive to gather this information on a large scale. Small follow-up surveys focusing on selected groups of patients can provide valuable information and faster feedback.
21 Glossary

Adult inpatient

Any person having at least one overnight stay (see below) and aged 16 years or over.

Ethics Committee

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. A favourable ethical opinion from the committee implies that the research does protect the participant’s aforementioned rights.

Multi-Centre Research Ethics Committee (MREC)

A MREC can grant a favourable ethical opinion for studies carried out in many regions of England. The inpatient survey has applied and been given a favourable ethical opinion for the study to be carried out in all acute NHS trusts in England.

Overnight stay

Patients are considered to have had an overnight stay if they were admitted as an inpatient and occupying a bed at midnight, ie patients who are admitted as an inpatient on Day 1 and discharged on Day 2 are considered to have had a single overnight stay regardless of their admission time or discharge time.

Obstetrics/Maternity patients

Any patients coded with a main specialty of 501 (obstetrics) or 560 (midwife) and admitted for management of pregnancy and childbirth, including miscarriages, should be excluded from the sample. A separate survey of maternity service users’ experiences is planned for 2007.

Psychiatry patients

Patients admitted as an inpatient to hospital for primarily psychiatry reasons should not be included in the sample. This will include all those with main specialties of:

- 700 learning disability
- 710 adult mental illness
- 711 child and adolescent psychiatry
- 712 forensic psychiatry
- 713 psychotherapy
- 715 old age psychiatry

Research Governance Framework

This outlines the principles of good research practice and is key to ensuring that health and social care research is conducted to high scientific and ethical standards.
Appendix 1: Declarations of data protection compliance

Declaration of compliance with the Data Protection Act 1998

DECLARATION
RELATING TO THE
[Name of survey eg 2005 Inpatient Survey]
FOR TRUSTS USING IN-HOUSE SURVEY TEAMS

While carrying out the [insert survey name], all trusts need to comply with:
• the Data Protection Act 1998,
• the NHS Code of Practice on Confidentiality, and
• the Caldicott principles.

Due to the large amount of patient information requested by the NHS patient survey programme, it has become necessary to regulate which individuals at a trust are able to view the raw data and some of the processed data. Only those trust staff who have completed this declaration will be authorised to view this restricted data. As the Caldicott Guardian is the designated person within the trust to supervise access to patient identifiable information, all declarations must be co-signed by the trust’s Caldicott Guardian. If the trust’s Caldicott Guardian does not authorise this, the trust must carry out the survey using an approved contractor.

For further information on the new guidelines, please see the “Data protection” section in the Guidance Manual for the [insert survey name].

I, [insert name of Caldicott Guardian] the Caldicott Guardian for [insert trust name] declare the aforementioned trust to be compliant with the Data Protection Act 1998 and will ensure that data collected while carrying out the NHS patient survey programme will conform to the guidelines set out under the section “Data protection” in the Guidance Manual for the [insert survey name here].

Signature: ………………………………………….. Date: ……………………………

I, [insert name of first survey lead] the first Survey Lead for [insert trust name] declare I understand the requirements of the Data Protection Act 1998 as they relate to the [insert survey name here] and will ensure that data collected while carrying out the NHS patient survey programme will conform to these requirements and the guidelines set out under the section “Data protection” in the Guidance Manual for the [insert survey name here].

Signature: ………………………………………….. Date: ……………………………

I, [insert name of second survey lead] the second Survey Lead for [insert trust name] declare I understand the requirements of the Data Protection Act 1998 as they relate to the [insert survey name here] and will ensure that data collected while carrying out the NHS patient survey programme will conform to these requirements and the guidelines set out under the section “Data protection” in the Guidance Manual for the [insert survey name here].

Signature: ………………………………………….. Date: ……………………………
Appendix 2: Declarations for additional data analysts

Declaration of compliance with the Data Protection Act 1998

DECLARATION
RELATING TO THE
[Name of survey eg 2005 Inpatient Survey]
Additional data analysts

If the trust requires additional data analysts to have access to the raw data set, this form must be completed and sent to the Coordination Centre, and a response received before access to the data set is granted. Only those trust staff who have completed this declaration will be authorised to view this restricted data. As the Caldicott Guardian is the designated person within the trust to supervise this access, all declarations must be co-signed by the Caldicott Guardian. If the Caldicott Guardian does not authorise this, the raw data set and responses from subgroups numbering less than twenty can only be viewed by the authorised survey leads.

For further information on the new guidelines, please see the “Data protection” section in the Guidance Manual for the [insert survey name].

I, [insert name of Caldicott Guardian] the Caldicott Guardian for [insert trust name] declare the aforementioned trust to be compliant with the Data Protection Act 1998 and will ensure that data collected while carrying out the NHS patient survey programme will conform to the guidelines set out under the section “Data protection” in the Guidance Manual for the [insert survey name here].

Signature: ………………………………………….. Date: ……………………………

I, [first additional data analyst] the first additional data analyst for [insert trust name] declare I understand the requirements of the Data Protection Act 1998 as they relate to the [insert survey name here] and will conform to these requirements and the guidelines set out under the section “Data protection” in the Guidance Manual for the [insert survey name here].

Signature: ………………………………………….. Date: ……………………………

I, [second additional data analyst] the second additional data analyst for [insert trust name] declare I understand the requirements of the Data Protection Act 1998 as they relate to the [insert survey name here] and will conform to these requirements and the guidelines set out under the section “Data protection” in the Guidance Manual for the [insert survey name here].

Signature: ………………………………………….. Date: ……………………………
Inpatients

The views of hospital inpatients in England
Key findings from the 2006 survey
Findings from the 2006 survey of hospital inpatients in England indicate that overall, patients reported a positive experience of their time in hospital, with more than nine in 10 rating the care they received as “excellent”, “very good” or “good”. More patients reported higher standards of cleanliness on wards, reduced waiting times for planned admissions and better written information about their care in 2006. But the findings from the fourth survey of inpatients in the NHS also reveal that more patients are reporting delays in staff responding to help buttons and not being fully informed about the purpose or side effects of their medicines.

How the survey was carried out

During autumn 2006, 141,447 patients were asked about their recent experiences as an inpatient at one of the 167 acute or specialist NHS trusts in England. Almost 81,000 patients took part in the survey, which, after taking account of undelivered questionnaires and those ineligible for inclusion, gave a response rate of 59%. Just over half of those who responded were women (55%), most were aged over 50 (74%), and 5% were from a black or minority ethnic group. To take part in the survey, patients had to be aged 16 or older and to have had at least one overnight stay in hospital during June, July or August 2006. They were admitted to hospital either via a planned admission from a GP referral list (55%) or urgently via the emergency department (45%). The survey did not include patients of maternity or psychiatric services.

Changes in the results over time may appear to be small – one or two percentage points – but they are significant because we are dealing with such large numbers of responses. Some percentages in this document differ slightly from previously published results because of the way in which figures have been rounded. Also, the results from the 2005 survey may differ slightly to those published last year. This is because the results presented here from 2005 are for respondents aged 16 or over, and those published last year were for those aged 18 or over. At the time, this enabled the 2005 findings to be compared with the 2004 survey, which had only included respondents aged 18 and over.

Why the survey was carried out

This is one of the largest annual surveys in the world asking about the experiences of people who have been admitted to an acute hospital. The questions in the survey cover the issues that patients have told us are the most important in their care. It offers an insight into their experiences and their perceptions about the treatment they receive. Understanding what patients think about their care and treatment is crucial to improving the quality of local services provided by the NHS.

This document reports the key findings from the survey at a national level, including significant changes from previous surveys. Detailed results are fed back to individual trusts to help them set priorities to ensure that they deliver a better service for patients. They are also used as part of the Healthcare Commission’s annual health check to help measure the quality of care being provided to patients. Measuring and reporting experiences in a structured way helps ensure that improving experiences for patients remains a priority for NHS trusts. Further detail, including the results of the survey for each trust, is available on the Healthcare Commission’s website at www.healthcarecommission.org.uk.
Key findings

Improvements have been identified in the following areas:

- 84% of patients whose admission was planned waited six months or less, compared with 78% in 2005, and 74% said they were admitted as soon as they thought necessary.

- More patients reported that doctors (69%) and nurses (71%) “always” washed or cleaned their hands between touching patients, compared with 67% and 69% in 2005.

- More patients said they received copies of letters sent between the hospital and their family doctor (37%) than in 2005 (35%).

Some aspects of care continue to be well regarded by a large majority of patients:

- 90% of patients “definitely” found ambulance staff reassuring.

- Most patients (88%) said they “always” had enough privacy when being treated or examined.

- 81% of patients said they “always” had complete confidence and trust in the doctor treating them.

- 84% of patients reported that their family and friends “definitely” or “to some extent” had an opportunity to talk to a doctor if they wanted to.

- 81% of those who had an operation or procedure said they were appropriately informed about the risks and benefits of their procedure.

However:

- 28% of patients admitted via the emergency department reported that they waited more than four hours for admission to a bed on a ward, slightly more than in 2005 (25%), but still substantially fewer than in 2002 (33%).

- More patients (15%) said it took staff over five minutes to answer the call button, compared with 13% in 2005.

- Of those who needed help to eat their meals, fewer (58%) said they always received it, down from 62% in 2005.

- Of those patients taking medicines home, 76% reported that they were told about the purposes of the medicines in a way they could “completely” understand, down from 79% in 2002. The proportion of patients saying they were told “completely” about any side effects has also fallen, from 40% in 2005 to 37%. However, more patients said they were given clear written or printed information about their medicines in 2006, up from 62% in 2005 to 65%.
Ambulance care

Just over half of the patients (54%) who were admitted to hospital as an emergency in 2006 travelled by ambulance, which is slightly more than in 2005. As in previous years, ambulance staff have been rated positively, and no significant changes were reported this year. Nine out of 10 patients “definitely” found ambulance staff reassuring, and 67% said that the ambulance crew “definitely” explained their care and treatment in a way they could understand. Just over three-quarters of patients (76%) said that everything had “definitely” been done to help control their pain.

The emergency department

Compared with 2005 (25%), a larger proportion of respondents (28%) reported waiting longer than four hours for admission to a bed on a ward after they had arrived at the emergency department. However, this is still better than in 2002, when 33% of patients reported that they waited longer than four hours to get a bed.

Fewer patients (77%) said they were “definitely” given enough privacy during examinations or treatment in the emergency department compared with 79% in 2005. A further 20% of patients reported that they had enough privacy “to some extent”. Of those admitted through an emergency department in 2006, a greater proportion (17%) said they had not received enough information about their treatment or condition, compared with 2005 (15%). The proportion of people who said they received the “right amount” of information decreased slightly from 73% in 2005 to 72% in 2006.

Waiting list or planned admissions

Overall, 95% of patients said they had been on a waiting list for nine months or less, compared with 92% in 2005. A larger proportion (24%) reported waiting three to six months in 2006, compared with 19% in 2005, which shows a significant shift towards admission before the waiting time target of six months or less.

More people (74%) also said they thought they were admitted “as soon as necessary”, up from 68% in 2002 and 72% in 2005. The proportion of people who said they should have been admitted “a lot sooner” fell to 8%, compared with 9% in 2005 and 12% in 2002. More than a quarter of people on a waiting list (27%) said they were offered a choice of admission date, but one-fifth (20%) reported that the hospital had changed their admission date at least once, which is similar to the 2005 survey finding, but slightly lower than in 2002 (22%).

Environment of the ward and hospital

Just under one third (30%) of patients who were admitted to hospital as an emergency said that they shared a sleeping area such as a room or bay with a member of the opposite sex when they were first admitted. For respondents who were moved to another ward, this proportion then falls to 16%. About one in 10 patients (11%) who had a planned admission to hospital said that they shared a sleeping area such as a room or bay with a member of the opposite sex when they were first admitted to hospital. This proportion remained the same (11%) for those patients who were moved to another ward.
The survey asked a series of questions to determine whether respondents had stayed on a mixed sex ward in hospital, and if so, at which point. Although it is recognised that in areas such as critical care units and the emergency department the clinical needs of the patients take priority over segregation by gender, trusts are still expected to do all that they reasonably can to segregate men and women. Accordingly, the survey results exclude those who said that they had stayed in a critical care area, and they look separately at emergency and planned admissions. We also separate out those respondents who were moved from one ward to another as this may further indicate they were originally in a critical care unit or emergency department.

Thirty per cent of all patients reported sharing a bathroom or shower area with patients of the opposite sex, while a further 2% said they shared facilities at least once during their stay because that area contained special bathing equipment which they needed. Compared with 2005, a slightly greater proportion of patients reported being bothered by noise at night. Thirty-eight per cent were bothered by noise made by other patients, compared with 37% in 2005 and 19% were bothered by noise made by hospital staff, compared with 18% in 2005.

The majority of patients (88%) rated the cleanliness of hospital toilets and bathrooms as “very clean” or “fairly clean”, compared with 87% in 2005. Over nine in 10 patients (93%) described the cleanliness of the hospital room or ward in which they were staying as “very clean” or “fairly clean” compared with 92% in 2005. There has been a slight improvement in the proportion of patients rating the cleanliness of their room or ward as “very clean”, up from 52% in 2005 to 53% in 2006. However, this is fewer than 2002, when 56% of patients rated the cleanliness of their room and ward as “very clean”.

This is the second year that a question has been asked about hand washing or cleaning, and some improvement has been reported. Sixty-nine per cent of patients reported that doctors “always” washed or cleaned their hands in 2006 compared with 67% in 2005, and 71% of patients said that nurses did compared with 69% in 2005.

Seventy per cent of patients said that they “always” had enough privacy when discussing their condition or treatment on the ward (compared with 71% in 2005), and a further 22% said that they “sometimes” had enough privacy. Most patients (88%) had enough privacy when being treated or examined, the same percentage as in 2005.

Since 2002, there has been little change in how patients have rated hospital food. As in 2002 (53%) and 2005 (54%), just over half of the patients surveyed in 2006 (54%) rated the food as “very good” or “good”. Almost four-fifths of patients (79%) said they were given a choice of food while in hospital.
Relationships with hospital staff

More than four in five patients (81%) “always” had complete confidence and trust in the doctor treating them. Seventy-three per cent of patients reported that they had complete confidence and trust in the nurses treating them in 2006, slightly fewer than in the 2005 survey (74%).

Doctors were more likely to “always” reply to patients’ questions with answers that they could understand (68%) in 2006, building on improvements seen in 2005 (67%) and from the 2002 survey (65%). More than four-fifths of patients (84%) reported that their family and friends had an opportunity to talk to a doctor if they wanted to. However, only two-fifths (42%) of patients said that, when leaving hospital, their family or someone else close to them “definitely” got all the information they needed to help them recover. A further 24% received this information “to some extent”.

Those aspects of communication highlighted in the 2005 survey as declining have continued to fall: 35% of patients reported that staff “sometimes or often” gave conflicting information, an increase from 34% in 2005 and 31% in 2002. There has been a steady increase since 2002 in patients saying they were unable to find a member of hospital staff to talk to about their fears or worries, up from 17% in 2002 to 22% in 2006. When asked about relationships between hospital staff, nine in 10 patients (92%) rated the way doctors and nurses worked together as “good,” “very good” or “excellent”, although fewer patients rated the teamwork between doctors and nurses as “excellent”, falling from 38% in 2005 to 36% in 2006.

Care and treatment of patients

Just over half of respondents (52%) said they were “definitely” involved as much as they wanted to be in decisions about their care and treatment, with 37% saying they were involved “to some extent”. There has been a slight increase in the percentage of patients saying they were not as involved as much as they wanted to be, up from 10% in 2005 to 11% in 2006. Again, as in 2005, almost four-fifths of patients (79%) said they were given the right amount of information about their treatment or condition, but more patients said that they were given too little information, up from 20% in 2005 to 21% in 2006. There has been a slight decrease in the percentage of patients who said they were “always” treated with respect and dignity, down from 79% in 2005 to 78%. Also, only 7% of respondents said they were asked to give their views on the quality of care they received while in hospital, and only 18% recalled being given information about how they could complain about their care if they felt this was necessary.

Slightly more patients in 2006 said they experienced pain while in hospital (67%, compared with 66% in 2005). There was no significant change in how well staff dealt with the patients’ pain, with 72% of patients saying staff definitely did everything they could to help control it.

In 2006, more patients (15%) reported that that it took over five minutes for a member of staff to answer the call button, compared with 13% in 2005. Of those patients who needed help to eat their meals, fewer (58%) said they always received it, down from 62% in 2005. The rise in the proportion of patients saying they did not get enough help from staff to eat their meals is concerning, increasing from 18% in 2005 to 20% in 2006.
Operations and procedures

More than two-thirds (68%) of patients responding to the survey had an operation or procedure while in hospital. They reported little change in the quality of the information compared with the 2005 survey. Of those patients having operations or procedures in 2006, four-fifths (81%) said that they were appropriately informed about the risks and benefits of their procedure, and around three-quarters (76%) said they had their questions answered in a way they could “completely” understand before an operation or procedure. Almost three-quarters of patients (74%) said they were told what would be done during the operation or procedure. Of those who received anaesthetic, 84% said they received complete explanations from the anaesthetist about what would happen.

Results have improved in terms of patients saying they were told how they could expect to feel after the operation, with over half (56%) saying they were told “completely” compared with 55% in 2005. There has also been an improvement in the proportion of patients who say they were fully informed about how the operation and procedure had gone in a way they could understand, rising from 63% in 2005 to 64% in 2006.

Leaving hospital

Nearly two in every five patients (38%) said that their discharge was delayed when they left hospital. More than one-fifth (21%) of these patients were delayed for four hours or more, most commonly because they were waiting for medicines to take home with them (61%). There has been no significant change in these figures since the 2005 survey.

Of those patients taking medicines home, only 76% said they were told “completely” about the purposes of the medicines in a way they could understand, down from 79% in 2002. A further 16% said they were informed “to some extent”. The proportion of patients who reported that they were told “completely” about the side effects has also fallen, from 40% in 2005 to 37%, with another 18% being informed “to some extent”. However, more patients said they were given clear written or printed information about their medicines in 2006, up from 62% in 2005 to 65%.

There has been a slight decrease in the number of patients who said that staff informed them “completely” of any danger signs they should watch for after they went home, falling from 40% in 2005 to 39% in 2006. Almost a quarter of respondents (24%) said they were not told who to contact if they were worried about their condition after leaving hospital. A greater proportion of patients (37%) reported receiving copies of letters between their hospital doctors and their family doctor, up from 35% in 2005.

Next steps

All trusts have received their own results for this survey, along with detailed information about how their results compared with other trusts. These findings will be used as part of our annual health check in 2006/2007, which assesses whether healthcare organisations are meeting the standards and targets set by the Government. They should also be used by NHS trusts to identify and address areas for improvement in the care and treatment of inpatients.

The next survey of inpatients will be carried out in autumn 2007.