Emergency Department Questionnaire

Taking part in this survey is voluntary

What is the survey about?

This survey is about your most recent visit to the Emergency Department (A&E, casualty) at the National Health Service Trust 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 questions, please call the helpline number given in the letter enclosed with this questionnaire.

Your answers will be treated in confidence

Please remember, this questionnaire is about your **most recent** visit to the Emergency Department of the NHS Trust named in the accompanying letter.

ARRIVAL AT THE EMERGENCY DEPARTMENT

1. How did you travel to the hospital?

1 ☐ In an ambulance
2 ☐ By car
3 ☐ By taxi
4 ☐ On foot
5 ☐ On public transport
6 ☐ Other

2. How would you rate the courtesy of the Emergency Department receptionist?

1 ☐ Excellent
2 ☐ Very good
3 ☐ Good
4 ☐ Fair
5 ☐ Poor
6 ☐ Very poor
7 ☐ I did not see a receptionist

WAITING

3. How long did you wait before you **first spoke** to a nurse or doctor?

1 ☐ 0 -15 minutes
2 ☐ 16 - 30 minutes
3 ☐ 31- 60 minutes
4 ☐ More than 60 minutes
5 ☐ Don't know/ Can't remember

4. Overall, did you think the order in which patients were seen was fair?

1 ☐ Yes
2 ☐ No
3 ☐ Can't say/ Don't know

5. From the time you first arrived at the Emergency Department, how long did you wait **before being examined** by a doctor or nurse practitioner?

1 ☐ I did not have to wait ➔ **Go to 7**
2 ☐ 1-30 minutes ➔ **Go to 6**
3 ☐ 31-60 minutes ➔ **Go to 6**
4 ☐ More than 1 hour but no more than 2 hours ➔ **Go to 6**
5 ☐ More than 2 hours but no more than 4 hours ➔ **Go to 6**
6 ☐ More than 4 hours ➔ **Go to 6**
7 ☐ Can't remember ➔ **Go to 6**
8 ☐ I did not see a doctor or a nurse practitioner ➔ **Go to 7**

6. Were you told **how long** you would have to wait to be examined?

1 ☐ Yes, but the wait was **shorter**
2 ☐ Yes, and I had to wait about as long as I was told
3 ☐ Yes, but the wait was **longer**
4 ☐ No, I was not told
5 ☐ Don't know/ Can't remember

7. Overall, how long did your visit to the Emergency Department last?

1 ☐ Up to 1 hour

2 ☐ More than 1 hour but no more than 2 hours

3 ☐ More than 2 hours but no more than 4 hours

4 ☐ More than 4 hours but no more than 8 hours

5 ☐ More than 8 hours but no more than 12 hours

6 ☐ More than 12 hours but no more than 24 hours

7 ☐ More than 24 hours

8 ☐ Can't remember

DOCTORS AND NURSES

8. Did you have **enough time** to discuss your health or medical problem with the doctor or nurse?

1 ☐ Yes, definitely ➔ **Go to 9**

2 ☐ Yes, to some extent ➔ **Go to 9**

3 ☐ No ➔ **Go to 9**

4 ☐ I did not see a doctor or a nurse ➔ **Go to 15**

9. While you were in the Emergency Department, did a doctor or nurse explain your condition and treatment in a way you could understand?

1 ☐ Yes, completely

2 ☐ Yes, to some extent

3 ☐ No

4 ☐ I did not need an explanation

10. Did the doctors and nurses listen to what you had to say?

1 ☐ Yes, definitely

2 ☐ Yes, to some extent

3 ☐ No

11. If you had any anxieties or fears about your condition or treatment, did a doctor or nurse discuss them with you?

1 ☐ Yes, completely

2 ☐ Yes, to some extent

3 ☐ No

4 ☐ I did not have anxieties or fears

12. Did you have confidence and trust in the doctors and nurses examining and treating you?

1 ☐ Yes, definitely

2 ☐ Yes, to some extent

3 ☐ No

13. In your opinion, did the doctors and nurses in the Emergency Department know enough about your condition or treatment?

1 ☐ All of them knew enough

2 ☐ Most of them knew enough

3 ☐ Only some of them knew enough

4 ☐ None of them knew enough

5 ☐ Don't know/ Can't say

14. Did doctors or nurses talk in front of you as if you weren't there?

1 ☐ Yes, definitely

2 ☐ Yes, to some extent

3 ☐ No

YOUR CARE AND TREATMENT

15. 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

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

1 ☐ Yes, definitely

2 ☐ Yes, to some extent

3 ☐ No

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

1 ☐ Yes, definitely

2 ☐ Yes, to some extent

3 ☐ No

18. If you needed attention, were you able to get a member of staff to help you?

1 ☐ Yes, always

2 ☐ Yes, sometimes

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1 ☐ Yes, definitely

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3 ☐ No

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21. Did the staff treating and assessing you introduce themselves?

1 ☐ Yes, all of the staff introduced themselves

2 ☐ Some of the staff introduced themselves

3 ☐ Very few or none of the staff introduced themselves

4 ☐ Don't know/ Can't remember

TESTS (e.g. x-rays or scans)

22. Did you have any tests (such as x-rays, scans or blood tests) when you visited the Emergency Department?

1 ☐ Yes ➔ **Go to 23**

2 ☐ No ➔ **Go to 24**

23. Did a member of staff explain **the results of the tests** in a way you could understand?

1 ☐ Yes, definitely

2 ☐ Yes, to some extent

3 ☐ No

4 ☐ Not sure/ Can't remember

5 ☐ I was told that the results of the tests would be given to me at a later date

6 ☐ I was never told the results of the tests

PAIN

24. Were you in any pain while you were in the Emergency Department?

1 ☐ Yes ➔ **Go to 25**

2 ☐ No ➔ **Go to 29**

25. While you were in the Emergency Department, how much of the time were you in pain?

1 ☐ All or most of the time

2 ☐ Some of the time

3 ☐ Occasionally

26. Did you request pain medicine?

1 ☐ Yes ➔ **Go to 27**

2 ☐ No ➔ **Go to 28**

27. How many minutes after you requested pain medicine did it take before you got it?

1 ☐ 0 minutes/right away

2 ☐ 1 - 5 minutes

3 ☐ 6 - 10 minutes

4 ☐ 11 - 15 minutes

5 ☐ 16 - 30 minutes

6 ☐ More than 30 minutes

7 ☐ I asked for pain medicine but wasn't given any

28. 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

4 ☐ Can't say/ Don't know

HOSPITAL ENVIRONMENT AND FACILITIES

29. In your opinion, how clean was the Emergency Department?

1 ☐ Very clean

2 ☐ Fairly clean

3 ☐ Not very clean

4 ☐ Not at all clean

5 ☐ Can't say

30. How clean were the toilets in the Emergency Department?

1 ☐ Very clean

2 ☐ Fairly clean

3 ☐ Not very clean

4 ☐ Not at all clean

5 ☐ I did not use a toilet

31. While you were in the Emergency Department, did you feel bothered or threatened by other patients?

1 ☐ Yes, definitely

2 ☐ Yes, to some extent

3 ☐ No

LEAVING THE EMERGENCY DEPARTMENT

32. What happened at the end of your visit to the Emergency Department?

1 ☐ I was admitted to the same hospital as an inpatient ➔ **Go to 40**

2 ☐ I was transferred to a different hospital or nursing home ➔ **Go to 40**

3 ☐ I went home ➔ **Go to 33**

4 ☐ I went to stay with a friend or relative ➔ **Go to 33**

5 ☐ I went to stay somewhere else ➔ **Go to 33**

Medications **(e.g. medicines, tablets, ointments)**

33. Before you left the Emergency Department, were any **new** medications prescribed or ordered for you?

1 ☐ Yes ➔ **Go to 34**

2 ☐ No ➔ **Go to 37**

34. Did a member of staff explain to you **how to take** the new medications?

1 ☐ Yes, completely

2 ☐ Yes, to some extent

3 ☐ No

4 ☐ I did not need an explanation

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

1 ☐ Yes, completely

2 ☐ Yes, to some extent

3 ☐ No

4 ☐ I did not need an explanation

36. Did a member of staff tell you about **medication side effects** to watch for?

1 ☐ Yes, completely

2 ☐ Yes, to some extent

3 ☐ No

4 ☐ I did not need this type of information

Information

37. Did a member of staff tell you when you could **resume your usual activities**, such as when to go back to work or drive a car?

1 ☐ Yes, definitely

2 ☐ Yes, to some extent

3 ☐ No

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38. Did a member of staff tell you about what **danger signals** regarding your illness or treatment to watch for after you went home?

1 ☐ Yes, completely

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3 ☐ No

4 ☐ I did not need this type of information

39. Did hospital staff tell you **who to contact** if you were worried about your condition or treatment after you left the Emergency Department?

1 ☐ Yes

2 ☐ No

3 ☐ Don't know / Can't remember

OVERALL

40. Was the main reason you went to the Emergency Department dealt with to your satisfaction?

1 ☐ Yes, completely

2 ☐ Yes, to some extent

3 ☐ No

41. Overall, did you feel you were treated with respect and dignity while you were in the Emergency Department?

1 ☐ Yes, all of the time

2 ☐ Yes, some of the time

3 ☐ No

42. Overall, how would you rate the care you received in the Emergency Department?

1 ☐ Excellent

2 ☐ Very good

3 ☐ Good

4 ☐ Fair

5 ☐ Poor

6 ☐ Very poor

ABOUT YOU

43. Are you male or female?

1 ☐ Male

2 ☐ Female

44. What was your year of birth?

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

45. 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

46. 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

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

1 ☐ Yes ➔ **Go to 48**

2 ☐ No ➔ **Go to 49**

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

1 ☐ Yes, definitely

2 ☐ Yes, to some extent

3 ☐ No

49. 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)

ANY OTHER COMMENTS

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

Was there anything particularly good about your visit to the Emergency Department?

Was there anything that could have been improved?

Any other comments?

THANK YOU VERY MUCH FOR YOUR HELP

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

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2 ☐ By car

3 ☐ By taxi

4 ☐ On foot

5 ☐ On public transport

6 ☐ Other

2. How would you rate the courtesy of the Emergency Department receptionist?

100 1 ☐ Excellent

80 2 ☐ Very good

60 3 ☐ Good

40 4 ☐ Fair

20 5 ☐ Poor

0 6 ☐ Very poor

- 7 ☐ I did not see a receptionist

WAITING

3. How long did you wait before you **first spoke** to a nurse or doctor?

100 1 ☐ 0 -15 minutes

67 2 ☐ 16 - 30 minutes

33 3 ☐ 31- 60 minutes

0 4 ☐ More than 60 minutes

- 5 ☐ Don't know/ Can't remember

4. Overall, did you think the order in which patients were seen was fair?

100 1 ☐ Yes

0 2 ☐ No

- 3 ☐ Can't say/ Don't know

5. From the time you first arrived at the Emergency Department, how long did you wait **before being examined** by a doctor or nurse practitioner?

100 1 ☐ I did not have to wait ➔ **Go to 7**

80 2 ☐ 1-30 minutes ➔ **Go to 6**

60 3 ☐ 31-60 minutes ➔ **Go to 6**

40 4 ☐ More than 1 hour but no more than 2 hours ➔ **Go to 6**

20 5 ☐ More than 2 hours but no more than 4 hours ➔ **Go to 6**

0 6 ☐ More than 4 hours ➔ **Go to 6**

- 7 ☐ Can't remember ➔ **Go to 6**

- 8 ☐ I did not see a doctor or a nurse practitioner ➔ **Go to 7**

6. Were you told **how long** you would have to wait to be examined?

100 1 ☐ Yes, but the wait was **shorter**

100 2 ☐ Yes, and I had to wait about as long as I was told

50 3 ☐ Yes, but the wait was **longer**

0 4 ☐ No, I was not told

- 5 ☐ Don't know/ Can't remember

7. Overall, how long did your visit to the Emergency Department last?

100 1 ☐ Up to 1 hour

83 2 ☐ More than 1 hour but no more than 2 hours

67 3 ☐ More than 2 hours but no more than 4 hours

50 4 ☐ More than 4 hours but no more than 8 hours

33 5 ☐ More than 8 hours but no more than 12 hours

17 6 ☐ More than 12 hours but no more than 24 hours

0 7 ☐ More than 24 hours

- 8 ☐ Can't remember

DOCTORS AND NURSES

8. Did you have **enough time** to discuss your health or medical problem with the doctor or nurse?

100 1 ☐ Yes, definitely → **Go to 9**

50 2 ☐ Yes, to some extent → **Go to 9**

0 3 ☐ No → **Go to 9**

-4 ☐ I did not see a doctor or a nurse → **Go to 15**

9. While you were in the Emergency Department, did a doctor or nurse explain your condition and treatment in a way you could understand?

100 1 ☐ Yes, completely

50 2 ☐ Yes, to some extent

0 3 ☐ No

-4 ☐ I did not need an explanation

10. Did the doctors and nurses listen to what you had to say?

100 1 ☐ Yes, definitely

50 2 ☐ Yes, to some extent

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11. If you had any anxieties or fears about your condition or treatment, did a doctor or nurse discuss them with you?

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67 2 ☐ Most of them knew enough

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14. Did doctors or nurses talk in front of you as if you weren't there?

0 1 ☐ Yes, definitely

50 2 ☐ Yes, to some extent

100 3 ☐ No

YOUR CARE AND TREATMENT

15. While you were in the Emergency Department, how much information about your condition or treatment was given to **you**?

50₁ ☐ Not enough

100₂ ☐ Right amount

50₃ ☐ Too much

0₄ ☐ I was not given any information about my treatment or condition

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

100₁ ☐ Yes, definitely

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0₃ ☐ No

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21. Did the staff treating and assessing you introduce themselves?

100₁ ☐ Yes, all of the staff introduced themselves

50₂ ☐ Some of the staff introduced themselves

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TESTS (e.g. x-rays or scans)

22. Did you have any tests (such as x-rays, scans or blood tests) when you visited the Emergency Department?

₁ ☐ Yes ➔ **Go to 23**

₂ ☐ No ➔ **Go to 24**

23. Did a member of staff explain **the results of the tests** in a way you could understand?

100 1 ☐ Yes, definitely

50 2 ☐ Yes, to some extent

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PAIN

24. Were you in any pain while you were in the Emergency Department?

1 ☐ Yes ➔ **Go to 25**

2 ☐ No ➔ **Go to 29**

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0₁ ☐ All or most of the time

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OVERALL

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100 1 ☐ Yes, completely

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100 1 ☐ Excellent

80 2 ☐ Very good

60 3 ☐ Good

40 4 ☐ Fair

20 5 ☐ Poor

0 6 ☐ Very poor

ABOUT YOU

43. Are you male or female?

1 ☐ Male

2 ☐ Female

44. What was your year of birth?

(Please write in) e.g.

1	9	3	4

45. 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

46. 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

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

1 ☐ Yes ➔ **Go to 48**

2 ☐ No ➔ **Go to 49**

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

1 ☐ Yes, definitely

2 ☐ Yes, to some extent

3 ☐ No

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

a. WHITE

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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)

ANY OTHER COMMENTS

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No stamp is needed.

Non survey variable definitions: A&E 2004/5 survey data

1. trustcod Trust code (please see table 1 or trust list_A&E (05).xls for the name of trusts)
2. trustnum: Trust number
3. record: Patient record number
4. YOB: Year of birth (where available, it may be preferable to use self reported year of birth, question 44)
5. sex: Gender, taken from the trusts' administrative systems, where available it may be preferable to use self reported gender instead (question 43)
    - Male=1
    - Female=2
6. Ethnic: ethnic group from sample information
    - White-1
    - Mixed-2
    - Asian/Asian British-3
    - Black/Black British-4
    - Chineese-5
    - Any other ethnic group-6
7. day: Day of attendance at department taken from trusts' administrative records
8. month Month of attendance at department taken from trusts' administrative records
9. year: Year of attendance at department taken from trusts' administrative records
10. outcome: Outcome of sending questionnaire
    - Returned useable questionnaire=1
    - Returned undelivered or pt moved house=2
    - Service user dies=3
    - Patient reported too ill to complete questionnaire=4
    - Patient was not eligible to fill in questionnaire=5
    - Questionnaire not returned - reason not known=6
11. comp_age Computed age, based on patient provide information (q44) where available or trusts administrative records (yob).

Table 1. Name and number of trusts

Trust code	Trust name
REM	Aintree Hospitals NHS Trust
RCF	Airedale NHS Trust
RDD	Basildon and Thurrock University Hospitals NHS Foundation Trust
RMC	Bolton Hospitals NHS Trust
RWY	Calderdale and Huddersfield NHS Trust
RW3	Central Manchester and Manchester Children's University Hospitals NHS Trust
RQM	Chelsea and Westminster Healthcare NHS Trust
RFS	Chesterfield and North Derbyshire Royal Hospital NHS Trust
RLN	City Hospitals Sunderland NHS Foundation Trust
RN7	Dartford and Gravesham NHS Trust
RC3	Ealing Hospital NHS Trust
RWH	East and North Hertfordshire NHS Trust
RJN	East Cheshire NHS Trust
RVV	East Kent Hospitals NHS Trust
RA4	East Somerset NHS Trust
RDE	Essex Rivers Healthcare NHS Trust
RLT	George Eliot Hospital NHS Trust
RQN	Hammersmith Hospitals NHS Trust
RCD	Harrogate Health Care NHS Trust
RD7	Heatherwood and Wexham Park Hospitals NHS Trust
RLQ	Hereford Hospitals NHS Trust
RAS	The Hillingdon Hospital NHS Trust
RWA	Hull and East Yorkshire Hospitals NHS Trust
RGQ	Ipswich Hospital NHS Trust
RR2	Isle Of Wight Healthcare NHS Trust
RNQ	Kettering General Hospital NHS Trust
RJZ	King's College Hospital NHS Trust
RCX	Kings Lynn and Wisbech Hospitals NHS Trust
RR8	Leeds Teaching Hospitals NHS Trust
RJ2	The Lewisham Hospital NHS Trust
RQ8	Mid Essex Hospital Services NHS Trust
RD8	Milton Keynes General Hospital NHS Trust
RP6	Moorfields Eye Hospital NHS Foundation Trust
RTX	Morecambe Bay Hospitals NHS Trust
RTD	The Newcastle Upon Tyne Hospitals NHS Trust
RNH	Newham University Hospital NHS Trust
RNL	North Cumbria Acute Hospitals NHS Trust
RAP	North Middlesex University Hospital NHS Trust
RJE	University Hospital Of North Staffordshire NHS Trust
RVW	North Tees and Hartlepool NHS Trust
RV8	North West London Hospitals NHS Trust
RBZ	Northern Devon Healthcare NHS Trust
RJL	Northern Lincolnshire and Goole Hospitals NHS Trust
RD3	Poole Hospitals NHS Trust
RHU	Portsmouth Hospitals NHS Trust
RQW	The Princess Alexandra Hospital NHS Trust
RFR	Rotherham General Hospitals NHS Trust
REF	Royal Cornwall Hospitals NHS Trust

RQ6	Royal Liverpool and Broadgreen University Hospitals NHS Trust
RA2	Royal Surrey County Hospital NHS Trust
RD1	Royal United Hospital Bath NHS Trust
RPR	Royal West Sussex NHS Trust
RNZ	Salisbury Health Care NHS Trust
RCC	Scarborough and North East Yorkshire Health Care NHS Trust
RHQ	Sheffield Teaching Hospitals NHS Foundation Trust
RK5	Sherwood Forest Hospitals NHS Trust
RM2	South Manchester University Hospitals NHS Trust
RTR	South Tees Hospitals NHS Trust
RE9	South Tyneside Health Care NHS Trust
RJC	South Warwickshire General Hospitals NHS Trust
RAJ	Southend Hospital NHS Trust
RVY	Southport and Ormskirk Hospital NHS Trust
RBN	St Helens and Knowsley Hospitals NHS Trust
RMP	Tameside and Glossop Acute Services NHS Trust
RBA	Taunton and Somerset NHS Trust
RA7	United Bristol Healthcare NHS Trust
RWD	United Lincolnshire Hospitals NHS Trust
RRV	University College London NHS Foundation Trust
RKB	University Hospitals Coventry and Warwickshire NHS Trust
RWE	University Hospitals Of Leicester NHS Trust
RBK	Walsall Hospitals NHS Trust
RBD	West Dorset General Hospitals NHS Trust
RFW	West Middlesex University Hospitals NHS Foundation Trust
RGR	West Suffolk Hospitals NHS Trust
RA3	Weston Area Health NHS Trust
RKE	The Whittington Hospital NHS Trust
RXP	County Durham and Darlington Acute Hospitals NHS Trust *
RXC	East Sussex Hospitals NHS Trust
RXN	Lancashire Teaching Hospitals NHS Trust
RXF	Mid Yorkshire Hospitals NHS Trust
RW6	Pennine Acute Hospitals NHS Trust
RXL	Blackpool, Fylde and Wyre Hospitals NHS Trust
RXH	Brighton and Sussex University Hospitals NHS Trust
RTE	Gloucestershire Hospitals NHS Foundation Trust
RXK	Sandwell and West Birmingham Hospitals NHS Trust
RXR	East Lancashire Hospitals NHS Trust
RXW	Shrewsbury and Telford Hospitals NHS Trust
RXQ	Buckinghamshire Hospitals NHS Trust
RN3	Swindon and Marlborough NHS Trust
RTF	Northumbria Health Care NHS Trust
RH8	Royal Devon and Exeter NHS Foundation Trust
RWJ	Stockport NHS Foundation Trust
RWP	Worcestershire Acute Hospitals NHS Trust
RBL	Wirral Hospital NHS Trust
RGP	James Paget Healthcare NHS Trust
RFF	Barnsley District General Hospital NHS Trust
RNS	Northampton General Hospital NHS Trust
RHW	Royal Berkshire and Battle Hospitals NHS Trust
RNA	Dudley Group Of Hospitals NHS Trust
RC1	Bedford Hospitals NHS Trust

RJ1	Guy's and St Thomas' NHS Foundation Trust
RDZ	Royal Bournemouth and Christchurch Hospitals NHS Trust
RL4	The Royal Wolverhampton Hospitals NHS Trust
RGC	Whipps Cross University Hospital NHS Trust
RJ6	Mayday Healthcare NHS Trust
RRF	Wrightington, Wigan and Leigh NHS Trust
RTK	Ashford and St Peter's Hospitals NHS Trust
RG2	Queen Elizabeth Hospital NHS Trust
RF4	Barking, Havering and Redbridge Hospitals NHS Trust
RJF	Burton Hospitals NHS Trust
RJ5	St Mary's NHS Trust
RBT	The Mid Cheshire Hospitals NHS Trust
RVL	Barnet and Chase Farm Hospitals NHS Trust
RA9	South Devon Health Care NHS Trust
RTG	Derby Hospitals NHS Foundation Trust
RJD	Mid Staffordshire General Hospitals NHS Trust
RHM	Southampton University Hospitals NHS Trust
RR7	Gateshead Health NHS Trust
RQX	Homerton University Hospital NHS Foundation Trust
RAL	Royal Free Hampstead NHS Trust
RAE	Bradford Teaching Hospitals NHS Foundation Trust
RDU	Frimley Park Hospital NHS Trust
RWW	North Cheshire Hospitals NHS Trust
RG3	Bromley Hospitals NHS Trust
RRK	University Hospital Birmingham NHS Foundation Trust
RCB	York Hospitals NHS Trust
RN1	Winchester and Eastleigh Healthcare NHS Trust
RR1	Birmingham Heartlands and Solihull (Teaching) NHS Trust
RJH	Good Hope Hospital NHS Trust
RPL	Worthing and Southlands Hospitals NHS Trust
RWF	Maidstone and Tunbridge Wells NHS Trust
RC9	Luton and Dunstable Hospital NHS Trust
RJR	Countess of Chester Hospital NHS Foundation Trust
RP5	Doncaster and Bassetlaw Hospitals NHS Foundation Trust
RPA	Medway NHS Trust
RNJ	Barts and The London NHS Trust
RQQ	Hinchingbrooke Health Care NHS Trust
RFK	Queen's Medical Centre, Nottingham University Hospital NHS Trust
RTH	Oxford Radcliffe Hospital NHS Trust
RM1	Norfolk and Norwich University Hospital NHS Trust
RN5	North Hampshire Hospitals NHS Trust
RJ7	St George's Healthcare NHS Trust
RWG	West Hertfordshire Hospitals NHS Trust
RM4	Trafford Healthcare NHS Trust
RM3	Salford Royal Hospitals NHS Trust
RK9	Plymouth Hospitals NHS Trust
RGZ	Queen Mary's Sidcup NHS Trust
RGN	Peterborough and Stamford Hospitals NHS Foundation Trust
RGT	Cambridge University Hospital NHS Foundation Trust
RVJ	North Bristol NHS Trust
RVR	Epsom and St Helier University Hospitals NHS Trust
RTP	Surrey and Sussex Healthcare NHS Trust

RAX Kingston Hospital NHS Trust

Trust code	Trust name
REM	Aintree Hospitals NHS Trust
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RQN	Hammersmith Hospitals NHS Trust
RCD	Harrogate Health Care NHS Trust
RD7	Heatherwood and Wexham Park Hospitals NHS Trust
RLQ	Hereford Hospitals NHS Trust
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RJD	Mid Staffordshire General Hospitals NHS Trust
RHM	Southampton University Hospitals NHS Trust
RR7	Gateshead Health NHS Trust
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RCB	York Hospitals NHS Trust
RN1	Winchester and Eastleigh Healthcare NHS Trust
RR1	Birmingham Heartlands and Solihull (Teaching) NHS Trust
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RFK	Queen's Medical Centre, Nottingham University Hospital NHS Trust
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RM1	Norfolk and Norwich University Hospital NHS Trust
RN5	North Hampshire Hospitals NHS Trust
RJ7	St George's Healthcare NHS Trust
RWG	West Hertfordshire Hospitals NHS Trust
RM4	Trafford Healthcare NHS Trust
RM3	Salford Royal Hospitals NHS Trust
RK9	Plymouth Hospitals NHS Trust
RGZ	Queen Mary's Sidcup NHS Trust
RGN	Peterborough and Stamford Hospitals NHS Foundation Trust
RGT	Cambridge University Hospital NHS Foundation Trust
RVJ	North Bristol NHS Trust
RVR	Epsom and St Helier University Hospitals NHS Trust
RTP	Surrey and Sussex Healthcare NHS Trust
RAX	Kingston Hospital NHS Trust

Healthcare Commission (CHAI)

Emergency Department Survey 2004/05

This document outlines the method used by the Healthcare Commission to group and score the performance indicator questions included in the Emergency Department Survey carried out by **Acute** trusts in Autumn 2004.

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 1.1).

Figure 1.1: Domains of patient experience

Domains:

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

2. Domains: Selected indicator questions

The core Emergency Department Survey consisted of 49 pre-coded questions, and one open-ended question. Of these, 36 questions were classed as potential evaluative questions and were allocated to one of the five domains.

The criteria listed in Figure 2.1 were used to assess the suitability of each individual question in terms of its viability as an indicator of performance. Using these criteria, 19 of the questions were then selected to be used as performance indicators. See Appendix 1.

Figure 2.1 Criteria for selecting performance indicator questions:

- Patient priorities:

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

- Wide range of issues within domains:

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

- Overlap:

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

- Numbers of questions in each domain:

  There should be between 3 and 8 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 2.

The scores represented the extent to which the patient's experience could be improved. A score of 0 was assigned to all responses that reflected considerable scope for improvement, whereas an answer option that was assigned a score of 100 referred to a positive patient experience. Options which did not have any bearing on the trusts performance in terms of patient experience, were classified as "not applicable" and a

score was not given to them. For example, where the patient stated they could not remember or did not know the answer to the question, a score was not given.

For example, question 41 (see Figure 3.1) in the Emergency Department Survey asked whether the respondent felt they were treated with respect and dignity. The option of "No" was allocated a score of 0, as this suggested that improvements to the patient experience were required. A score of 100 was assigned to the option "Yes, all of the time" as it reflected a positive patient experience. The remaining option, "Yes, some of the time", was assigned a score of 50 as the patient felt that some degree of respect and dignity was received, although not consistently. Hence it was placed on the midpoint of the scale.

Figure 3.1 Scoring example: Question 41

41. Overall, did you feel you were treated with respect and dignity while you were in the Emergency Department?	
Yes, all of the time	100
Yes, some of the time	50
No	0

Where a number of options lay between the negative and positive responses, they were placed in appropriate positions along the scale. For example, question 5 in the Emergency Department Survey asked how long the patient waited before being examined by a doctor or nurse practitioner (see Figure 3.2 overleaf). The options include:

- I did not have to wait
- 1-30 minutes
- 31-60 minutes
- More than 1 hour but no more than 2 hours
- More than 2 hours but no more than 4 hours
- More than 4 hours
- Can't remember
- I did not see a doctor or a nurse practitioner

A score of 100 was assigned to the response that the patient "did not have to wait" as this is best practice in terms of patient experience. A response that it took "More than 4 hours" was given a score of 0, and so the remaining four answers were assigned a score that reflected their position in terms of best practice, spread evenly across the scale. Hence the option "1-30 minutes" was assigned a score of 80, "31-60 minutes" achieved a score of 60, "More than 1 hour but no more than 2 hours" was 40 and the response that it took "More than 2 hours but no more than 4 hours" was scored 20 for the trust.

If the patient did not see a doctor or a nurse practitioner, or could not remember how long it had taken, this would be classified as a "not applicable" response, as these

options were not direct measures of how long a person had to wait to for an examination by a doctor or nurse practitioner.

Figure 3.2 Scoring example: Question 5

5. Following the time your first arrived in the Emergency Department, how long did you wait before being examined by a doctor or nurse practitioner?	
I did not have to wait	100
1-30 minutes	80
31-60 minutes	60
More than 1 hour but no more than 2 hours	40
More than 2 hours but no more than 4 hours	20
More than 4 hours	0
Can't remember	Not applicable
I did not see a doctor or a nurse practitioner	Not applicable

4. Methodology: Overall domain scores

The scores for each domain in each trust were calculated using the method, described in sections 4.1 to 4.5.

To summarise, age-by-sex weightings were calculated to adjust for any variation between trusts that resulted from differences in the age and sex of respondents. A weight was calculated for each respondent by dividing the national proportion of respondents in their age-by-sex group by the corresponding trust proportion. As shown in section 4.4, the final domain score was calculated by dividing the sum of weighted scores for all eligible responses by the weighted number of eligible respondents for each question that contributes 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 and women tended to be more critical in their responses than older people and men. If a trust had a large population of young people or women, their performance might be judged more harshly than if there was a more consistent age/sex distribution.

The exact stages are described in detail in the next four sections.

4.1 Weighted analysis

The first stage of the analysis involved calculating national age-by-sex 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 UK population.

The questionnaire asked respondents to state their year of birth. The approximate age of the respondents was then calculated by subtracting the figure from 2004. The respondents are then grouped according to the categories shown in figure 4.1.1.

If a respondent did not fill in their age group or sex within the questionnaire, this information was copied 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 respondent was excluded from the analysis.

The national age-by-sex proportions related to the proportion of men and women within each age group. With the Emergency Department Survey, as shown in Figure 4.1.1, the proportion of men aged 51-65 years was 0.108 the proportion of women aged 51-65 years was 0.117, etc.

Figure 4.1.1 National Proportions (Emergency Department)

Sex	Age Group	National Proportion
Men	16-35	0.11361382
	36-50	0.11399963
	51-65	0.10790006
	66+	0.12311225
Women	16-35	0.1447731
	36-50	0.12061363
	51-65	0.11693919
	66+	0.15904832

The trust age-by-sex proportions were also calculated individually for each set of trust data, using the same procedure.

The next step was to calculate the weighting for each individual's responses. Age-by-sex weightings were calculated for each respondent by dividing the national proportion of respondents in their age-by-sex group by the corresponding trust proportion.

If, for example, a lower proportion of men aged between 16 and 35 years within Trust A responded to the survey, in comparison with the national proportion, then this group would be under-represented in terms of the final scores. Dividing the national proportion by the trust's proportion would result in a greater weighting for members of this group (see Figure 4.1.2). This would increase the influence of responses made by respondents within that group over the final score, thus counteracting the low representation.

Figure 4.1.2 Proportion and Weighting for Trust A

Sex	Age Group	National Proportion	Trust A Proportion	Trust A Weight (National/Trust A)
Men	**16-35**	**0.114**	**0.036**	**3.167**
	36-50	0.114	0.070	1.629
	51-65	0.108	0.094	1.149
	66+	0.123	0.190	0.647
Women	16-35	0.145	0.090	1.611
	36-50	0.121	0.115	1.052
	51-65	0.117	0.171	0.684
	66+	0.159	0.235	0.677

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 aged between 66+ from Trust B responded to the survey (see Figure 4.1.3), then this group would be over-represented within the sample, compared with national representation of this group. Subsequently this age group would have a greater influence over the final score. To counteract this, dividing the national proportion by the proportion for Trust B would result in a lower weighting for members of this group, and would in effect reduce the disproportionate influence held by this group.

Figure 4.1.3 Proportion and Weighting for Trust B

Sex	Age Group	National Proportion	Trust B Proportion	Trust B Weight (National/Trust B)
Men	16-35	0.114	0.033	3.455
	36-50	0.114	0.059	1.932
	51-65	0.108	0.125	0.864
	66+	**0.123**	**0.183**	**0.672**
Women	16-35	0.145	0.068	2.132
	36-50	0.121	0.151	0.801
	51-65	0.117	0.160	0.731
	66+	0.159	0.220	0.723

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

4.2 Obtaining the numerators for each domain score

The responses given by each respondent were entered into a dataset in terms of 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 (see Figure 4.2.1).

Figure 4.2.1 Scoring for "Clean, comfortable, friendly place to be" domain, Trust A (Emergency Department)

Respondents	Question:				Weight
	17	28	29	41	
1	100	50	67	100	1.629
2	50	100	100	.	0.647
3	.	.	67	100	1.052

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

Figure 4.2.2 Numerators for "Clean, comfortable, friendly place to be" domain, Trust A (Emergency Department)

Respondents	Numerators:				Weight
	17	28	29	41	
1	162.900	81.450	109.143	162.900	1.629
2	32.350	64.700	64.700		0.647
3			70.484	105.200	1.052

4.3 Obtaining the denominators for each domain score

A second dataset was then created. This contained a column for each question, with each row corresponding to an individual respondent. A value of one was entered for the questions whereby a response had been given by the respondent, and all questions that had been left unanswered or allocated a scoring of "not applicable" (see section 3) were set to missing (see Figure 4.3.1).

Figure 4.3.1 Values for non-missing responses, "Clean, comfortable, friendly place to be" domain, Trust A (Emergency Department)

Respondents	Question:				Weight
	17	28	29	41	
1	1	1	1	1	1.629
2	1	1	1		0.647
3			1	1	1.052

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 (see 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 "Clean, comfortable, friendly place to be" domain, Trust A (Emergency Department)

Respondents	Denominators:				Weight
	17	28	29	41	
1	1.629	1.629	1.629	1.629	1.629
2	0.647	0.647	0.647	.	0.647
3	.	.	1.052	1.052	1.052

4.4 Final calculation

The final score for each domain was calculated via a two-step process. Firstly, weighted mean scores were calculated for each of the questions that contributed 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) at 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 A, we first calculated weighted mean scores for each of the three questions that contributed to the 'Clean, comfortable, friendly place to be' domain:

Q17: $\frac{162.9+32.35}{1.629+0.647} = 85.786$

Q28: $\frac{81.45+64.7}{1.629+0.647} = 64.214$

Q29: $\frac{109.143+64.7+70.484}{1.629+0.647+1.052} = 73.416$

Q41: $\frac{162.9+105.2}{1.629+1.052} = 100.000$

The final domain score would be given as a mean of these four values:

$$\frac{85.786+64.214+73.416+100.000}{4} = 80.854$$

This process was repeated for each of the domains defined within the survey. 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 2004/05 star ratings were banded using the same methodology as that used in 2003/04. 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

More technical details on the calculation of the Z_D score can be found in appendix 3. 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 (ie 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 1: Performance indicator questions, grouped within each Emergency Department Survey domain

Access and Waiting
3. How long did you wait before you **first spoke** to a nurse or doctor? 5. Following the time your first arrived in the Emergency Department, how long did you wait before being examined by a doctor or nurse practitioner? 7. Overall, how long did your visit to the Emergency Department last?

Safe, high quality, coordinated care
12. Did you have confidence and trust in the doctors and nurses examining and treating you? 19. Sometimes in a hospital, a member of staff will say one thing and another will say something quite different. Did this happen to you in the Emergency Department? 38. Did a member of staff tell you about what danger signals regarding your illness or treatment to watch for after you went home?

Better information, more choice
15. While you were in the Emergency Department, how much information about your condition or treatment was given to you? 20. Were you involved as much as you wanted to be in decisions about your care and treatment? 35. Did a member of staff explain the purpose of the medications you were to take at home in a way you could understand? 36. Did a member of staff tell you about medication side effects to watch for?

Building relationships
8. Did you have enough time to discuss your health or medical problem with the doctor or nurse? 9. While you were in the Emergency Department, did a doctor or nurse explain your condition and treatment in a way you could understand? 10. Did doctors and nurses listen to what you had to say? 11. If you had any anxieties or fears about your condition or treatment, did a doctor or nurse discuss them with you? 14. Did doctors or nurses talk in front of you as if you weren't there?

Clean, comfortable, friendly place to be
17. Were you given enough privacy when being examined or treated?
28. Do you think hospital staff did everything they could to help control your pain?
29. In your opinion, how clean was the Emergency Department?
41. Overall, did you feel you were treated with respect and dignity while you were in the Emergency Department?

Appendix 2: Scoring of individual indicator questions
Emergency Department Survey

5. Following the time your first arrived in the Emergency Department, how long did you wait before being examined by a doctor or nurse practitioner?	
I did not have to wait	100
1-30 minutes	80
31-60 minutes	60
More than 1 hour but no more than 2 hours	40
More than 2 hours but no more than 4 hours	20
More than 4 hours	0
Can't remember	Not applicable
I did not see a doctor or a nurse practitioner	Not applicable

3. How long did you wait before you first spoke to a nurse or doctor?	
0-15 minutes	100
16-30 minutes	67
31-60 minutes	33
More than 60 minutes	0
Don't know/Can't remember	Not applicable

7. Overall, how long did your visit to the Emergency Department last?	
Up to 1 hour	100
More than 1 hour but no more than 2 hours	83
More than 2 hours but no more than 4 hours	67
More than 4 hours but no more than 8 hours	50
More than 8 hours but no more than 12 hours	33
More than 12 hours but no more than 24 hours	17
More than 24 hours	0
Can't remember	Not applicable

8. Did you have enough time to discuss your health or medical problem with the doctor or nurse?	
Yes, definitely	100
Yes, to some extent	50
No	0
I did not see a doctor or a nurse	Not applicable

9. While you were in the Emergency Department, did a doctor or nurse explain your condition and treatment in a way you could understand?	
Yes, completely	100
Yes, to some extent	50
No	0
I did not need an explanation	Not applicable

10. Did the doctors and nurses listen to what you had to say?	
Yes, definitely	100
Yes, to some extent	50
No	0

11. If you had any anxieties or fears about your condition or treatment, did a doctor or nurse discuss them with you?	
Yes, completely	100
Yes, to some extent	50
No	0
I didn't have anxieties or fears	Not applicable

12. Did you have confidence and trust in the doctors and nurses examining and treating you?	
Yes, definitely	100
Yes, to some extent	50
No	0

14. Did doctors or nurses talk in front of you as if you weren't there?	
Yes, definitely	0
Yes, to some extent	50
No	100

15. While you were in the Emergency Department, how much information about your condition or treatment was given to you?	
Not enough	50
Right amount	100
Too much	50
I was not given any information about my treatment or condition	0

17. Were you given enough privacy when being examined or treated?	
Yes, definitely	100
Yes, to some extent	50
No	0

19. Sometimes in a hospital, a member of staff will say one thing and another will say something quite different. Did this happen to you in the Emergency Department?	
Yes, definitely	0
Yes, to some extent	50
No	100

20. Were you involved as much as you wanted to be in decisions about your care and treatment?	
Yes, definitely	100
Yes, to some extent	50
No	0
I was not well enough to be involved in decisions about my care	Not applicable

28. Do you think the hospital staff did everything they could to help control your pain?	
Yes, definitely	100
Yes, to some extent	50
No	0
Can’t say/ Don’t know	Not applicable

29. In your opinion, how clean was the Emergency Department?	
Very clean	100
Fairly clean	67
Not very clean	33
Not at all clean	0
Can’t say	Not applicable

35. Did a member of staff explain the purpose of the medications you were to take at home in a way you could understand?	
Yes, completely	100
Yes, to some extent	50
No	0
I did not need an explanation	Not applicable

36. Did a member of staff tell you about medication side effects to watch for?	
Yes, completely	100
Yes, to some extent	50
No	0
I did not need this type of information	Not applicable

38. Did a member of staff tell you about what danger signals regarding your illness or treatment to watch for after you went home?	
Yes, completely	100
Yes, to some extent	50
No	0
I did not need this type of information	Not applicable

41. Overall, did you feel you were treated with respect and dignity while you were in the Emergency Department?	
Yes, all of the time	100
Yes, some of the time	50
No	0

Appendix 3: 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. This 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 2004/05 star ratings, 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:

$$z_i = \frac{y_i - \theta_0}{s_i} \qquad (1)$$

where s_i is the standard error of the trust mean score, y_i is the trust domain score, and θ_0 is the national mean score (the target against which the trusts are being judged). However, because 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 you cannot control for all the factors that may affect a trust's score. 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'. This 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 Z_D score). Under this 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 Z_D 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 2004/2005 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 standardized rates.

Winsorising Z-scores

The first step when calculating Z_D 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 $\hat{\phi}$ is less than 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 θ_i (trust means) for trusts which are on target, we give this value the symbol $\hat{\tau}$. $\hat{\tau}$ may is estimated using the following formula:

$$\hat{\tau}^2 = \frac{I\hat{\phi} - (I-1)}{\sum_i w_i - \sum_k w_i^2 \Big/ \sum_i w_i} \quad (3)$$

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

$$z_i^D = \frac{y_i - \theta_0}{\sqrt{s_i^2 + \hat{\tau}^2}} \quad (4)$$

For a worked example using this method, please refer to the 'explanation of statistical methods' document in the 'more information' section of the 2004 ratings website. Please note however, that where in that s_i^0 is used, we simply use s_i for the surveys data.

NHS National Patient Survey Programme: data weighting issues

1. Introduction

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

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

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

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

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

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

2. Samples

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

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

Table 1 Summary of sampling methods

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

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

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

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

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

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

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

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

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

3. Weighting the results

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

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

4. Illustrative example

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

Table 2 Students and smoking

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

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

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

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

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

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

5. Weighting for national level patient survey estimates

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

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

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

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

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

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

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

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

Table 3 Weighting to trust population

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

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

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

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

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

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

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

Estimate = 340.6667 / 1400 = 0.2433

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

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

Dealing with missing data and filtered questions

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

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

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

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

What weight should be used?

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

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

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

Calculating patient population weights

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

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

where:

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

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

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

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

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

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

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

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

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

Patten Smith
4 November 2005

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

NHS PATIENT SURVEY PROGRAMME

ACUTE TRUSTS: A&E Survey 2004/5

About the survey

The A&E Survey 2004/5 is part of the NHS Patient Survey Programme, initiated by the Department of Health and now the responsibility of the Healthcare Commission (CHAI). More than 55,000 patients from 153 NHS trusts in England participated in this survey. The survey was designed to provide actionable feedback to each participating trust on patients' views of the care they had received, as well as providing CHAI with patient focused indicators to feed into the 2005 performance ratings for acute and specialist NHS trusts. Further details of the survey methodology can be found in the separate note on the website.

About the benchmarking reports

Each report presents question level results for an individual trust. A&E questionnaire contained 49 precoded questions, 36 of which could be evaluated as an indicator of performance. These 36 questions were allocated to one of the five domains of patient experience used by the Department of Health:

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

An 'overall impression' question asked patients to rate the care they had received in the emergency department. This report presents the results on each evaluative question within these five domains as a set of charts and tables.

Reports may be found:
http://www.healthcarecommission.org.uk/NationalFindings/Surveys/PatientSurveys/fs/en?CONTENT_ID=4014140&chk=EDYpKy

Interpreting the charts

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

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

The bar is divided into three coloured segments:

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

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

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

Further information

Full details of the survey methodology can be found at:
http://www.nhssurveys.org/docs/Emergency_Guidance2005_V3.pdf

More information on the NHS Patient Survey Programme is available on the NHS Surveys Advice Centre website:
http://www.nhssurveys.org/

The questionnaire and scores given to each response can be found at:
http://www.healthcarecommission.org.uk/PatientSurveyAandE2004

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

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

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

NHS trust-based patient surveys: acute hospital trusts

Emergency Departments 2004/05

Listening to your patients

Rachel Reeves, Picker Institute Europe

Last updated 2 August 2004

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

http://www.NHSSurveys.org

Contacts

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

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

Updates

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

Outpatients Survey

Acute NHS Trusts will also be required to carry out a survey of Outpatients Departments in 2004/05. A separate guidance manual, questionnaire and question bank for the Outpatients survey will be available from the NHS Surveys Advice Centre website.

Changes to the procedures outlined in this document

It is not permissible to deviate from the agreed protocol as set out in the guidance manual. For example, offering financial inducements or lottery prizes to respondents. We do not recommend translation of questionnaires into other languages. More guidance on how to reach ethnic minority groups can be found in Section 7. 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 this could affect the calculation of performance indicators. 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 Advice Centre that the proposed alteration would not compromise comparability.

Please direct questions or comments about this guidance to:

rachel.reeves@pickereurope.ac.uk

CONTENTS

1 Introduction: patient feedback and the NHS Plan

1.1 The Healthcare commission

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

1.2 Why we need patient feedback

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

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

1.3 Patient feedback and the NHS Plan

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

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

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

1.4 Performance indicators

Information drawn from the core questions of the Emergency Survey will be used by the Healthcare Commission to create headline NHS Performance Indicators. These indicators will be used in Acute and Specialist Trust Performance Ratings, due for publication in the summer 2005. The results will also be used in the Healthcare Commission reviews of Emergency Departments in 2004/05.

In addition to the performance indicators, 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 surveys of both Outpatients and Emergency Department patients 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 a bi-annual basis, trusts will be able to monitor their own performance over time.

1.5 Basic requirements for Emergency Department surveys

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

- You must contact the Survey Advice Centre by **30 July 2004** and tell them who is carrying out your survey (i.e. whether it will be carried out by an approved contractor or in-house), and who in your trust will be responsible for monitoring survey's progress (e-mail: acute.data@pickereurope.ac.uk).
- A postal questionnaire survey must be carried out, with **two reminders sent to non-responders**, even if the minimum 50% response rate is already achieved.
- A random sample of patients must be taken from all eligible patient attendances in one month. (The month should be June 2004, July 2004 or August 2004.)
- The sampling procedure set out in this guidance must be followed. To do this, you will need to work closely with the person in Patient Information who draws the sample, and check carefully that this guidance has been adhered to. See Section 9 - *Compiling a list of patients.*
- You should aim to obtain the highest response rate possible. For this survey, the target minimum is 50%, but many trusts will achieve higher response rates than that. Three mailings will be necessary to achieve this target.
- The questionnaire must include the 49 core questions. See Section 11 - *The Emergency Survey Core Questions and question bank.*
- The data must be checked carefully for errors before submitting it to the Advice Centre. See Section 14 - *Entering data*
- The data from the core questions, and the required information about the patient sample, must be submitted to the Survey Advice Centre in the form outlined in 14.5 - *Submitting data to the Patient Survey Advice Centre* by **5 November 2004**.
- Two paper copies each of the questionnaire you used, and the covering letters for **each mailing,** must be submitted to the Survey Advice Centre in the form outlined in 14.5 - *Submitting data to the Patient Survey Advice Centre* by **5 November 2004**.
- You must keep paper copies (or scanned pictures of all of the pages of the questionnaires, including the front and back pages) of all questionnaires returned to you until 30 April 2005 but please **do not** send these to the Advice Centre.
- You must keep a copy of the patient sample information (i.e. their names, addresses, year of birth ethic group, gender, attendance dates) until 31st December 2004, in case your trust is included in the non-response follow-up survey to be carried out by researchers at BMRB.

1.6 How to use this guide

Trusts have the option of conducting the survey in house or using an approved contractor (see Section 4). Whichever route you take, you will need to address the guidance in Sections 1 to 11 and 15 to 16 of this guide. Sections 12 to 14 cover the practicalities of mailing out the survey, following-up responses and processing the data, and submitting it to the Advice Centre. These sections will be most relevant to approved contractors, or trusts undertaking the surveys themselves.

2 Setting up a project team

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

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

3 Approved Survey Contractor versus in-house surveys

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

- Costs
- Quality and confidence in the findings
- Timing
- Human resources

3.1 Costs

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

Staff time

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

Materials

Stationery and postage

You will need to cover stationery and postage for three mailings. The first mailing will go out to 850 patients and second and third mailings will be sent only to non-responders. (See Section 12 – *Materials* for more details.) You will also need to cover the cost of second class postage for three mailings, two of which will be greater than the standard letter rate, while the second mailing (first reminder slip) will be standard letter rate.

FREEPOST licence

The FREEPOST address can be printed on return envelopes so that respondents can send back the survey at no cost to themselves. There is a charge for obtaining a FREEPOST licence. (For details, see 13.1 - *Setting up a FREEPOST address*.)

FREEPHONE service

This service gives patients easy access to advice and staff can reassure them on any concerns they have about the survey. The cost of setting up the service and of staff time in responding needs to be considered. (For details, see 13.2 - *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. You will need to allow enough time for agreeing the details of a contract with a company and discussing their specific requirements (such as the size of the response boxes). If you use in-house scanning equipment, allow time for setting it up to read the data correctly from questionnaires.

Design and production of reports

This requires a considerable amount of skilled staff time.

3.2 Quality and confidence in the findings

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

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

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

3.3 Timing

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

3.4 Human resources

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

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

N.B. When you have decided who will carry out your survey, you must inform the Advice Centre by **30 July 2004.**

4 Commissioning a survey from an Approved Contractor

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

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

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

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

4.1 List of approved contractors

Ipsos-RSL

Contact: Sam McGuire

Head of Social & Public Sector Research
Ipsos – RSL
Kings House
Kymberley Road
Harrow
HA1 1PT
Tel: 0208 861 8703
Fax: 0208 863 0957
E-mail: sam.mcguire@ipsos.com

Maritz

Contact: Gavin Sugden
Associate Director
Maritz Research
Seagate House
Globe Park
Marlow
SL7 1LW

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

Market Research UK

Contact: Craig Taylor; Jo Cleaver; Rachel Cope

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

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

Marketing Sciences

Contact: Eileen Sutherland

Marketing Sciences
8 Clement Street
Winchester
Hants
SO23 9DR

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

Market & Opinion Research International (MORI)

Contacts: Ben Cooke, Mark Gill

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

Tel: 0207 347 3000
Fax: 0207 347 3800
E-mail: ben.cooke@mori.com; mark.gill@mori.com
Website: www.mori.com

MSB Ltd

Contact: Stephen Harwood

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

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

NOP

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

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

Tel: 0207 890 9000 (Switchboard)
Fax: 0207 890 9744
E-mail: r.glendinning@nopworld.com; t.buchanan@nopworld.com;
c.ivins@nopworld.com; s.mchugh@nopworld.com

Website: www.nop.co.uk

ORC International

Contact: Rory MacNeill

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

Tel: 0207 675 1066
Fax: 0207 675 1908
E-mail: rory.macneill@orc.co.uk; patientsurvey@orc.co.uk

Patient Dynamics

Contact: Andrew Smith

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

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

Picker Institute Europe

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

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

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

Quality Health

Contact: Dr Reg Race

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

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

Taylor Nelson Sofres

Contact: Susannah Quick

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

Tel: 0208 334 4200
Fax: 0208 334 4227
Email: Susannah.quick@tns-global.com
Website: www.tnsofres.com

Contracts

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

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

5 Data protection and confidentiality

You will need to ensure that you comply with the Data Protection Act 1998, and that patient responses are kept confidential. You will also need to comply with the NHS Code of Practice on Confidentiality and the Caldicott Guidance (about which, more detail is given below).

As a part of this, you will need to take care 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 matters of confidentiality and data protection.

The website below has further information:

http://www.dh.gov.uk/PolicyAndGuidance/InformationTechnology/PatientConfidentialityAndCaldicottGuardians/Caldicott/fs/en

5.1 Caldicott

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

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

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.

Further information about the Data Protection Act can be found at:

http://www.informationcommissioner.gov.uk

5.2 Patients' names and addresses

In general, to comply with the Data Protection Act, NHS Trusts should not release the names, addresses and other personal details of patients to anyone who is not employed by the trust, unless appropriate security and contractual measures are in place. This includes releasing names and addresses for the purpose of mailing survey questionnaires to patients.

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

1. The contractor delivers pre-packed serial-numbered envelopes containing questionnaires, covering letters and FREEPOST envelopes to the trust. The trust then attaches number-matched address labels to the envelopes and sends them out to patients. Completed questionnaires can then be returned to the contractor and, by checking the Record Numbers on returned questionnaires, they can inform the trust which patients need to be sent reminders. This process is described in more detail in Sections 9 and 13.

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

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

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

5.3 Sample Honorary Contract

[Name of NHS Trust]

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

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

FORM OF ACCEPTANCE

I hereby accept the terms and conditions set out above.

Signed: …… Date:……..

[Name of employee]

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

[NHS Trust]

Date:……..

5.4 Patient confidentiality

It is essential that any patient survey is conducted in such a way that respects patient confidentiality. That is, patients must be assured that doctors, nurses and other healthcare workers will not be able to identify individual patients' responses. Furthermore, their responses must not be presented to anyone in a way that allows individuals to be identified. For example, if a patient is known to have visited a particular department, 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. We would recommend that patient responses should be aggregated into groups of no less than 30 patients before data are presented to staff.

5.5 Patient anonymity

In-house surveys

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

Approved Contractors

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

5.6 Storing completed questionnaires

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

Any mailing lists of patients' names and addresses should be destroyed when the mailing process is complete, but **do not destroy it before 31st December 2004** as your trust might be included in the non-response follow-up survey to be carried out by BMRB.

6 Ethical issues, ethics committees & research governance

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

6.1 Ethical approval for the survey

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

You do not, therefore, need to seek ethical approval for this survey. You should inform the relevant Local Research Ethics Committees (LREC(s)) and/or send them a copy of the MREC approval letter. You do not need to wait for confirmation or approval from the LREC before starting your survey. The MREC letters can be downloaded the NHSSurveys website.

6.2 Ethical approval for adding your own questions

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

6.3 Further information on ethical approval

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

6.4 Research governance requirements

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

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

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

The Department of Health has confirmed to 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 to sponsor. 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.

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

References

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

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

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

6.5 Responsibilities of organisations providing care

Research Governance Framework	**The Healthcare Commission patient surveys**
Retain responsibility for the quality of all aspects of participants' care whether or not some aspects of care are part of a research study.	*The survey is carried out on the experiences of patients after they have received the care so this does not apply.*
Be aware and maintain a record of all research undertaken through or within the organisation, including research undertaken by students as part of their training.	*All Chief Executives are informed of the proposals of the survey. Similar letter has been sent to the R&D Managers of the trusts.*
Ensure patients or users and carers are provided with information on research that may affect their care.	*The survey does not affect the care of the patients. Anonymised results are used for performance rating and local quality improvement initiatives. Detailed guidance is issued to survey leads regarding the publicity of the results and its impact on patient care.*
Be aware of current legislation relating to research and ensure that it is implemented effectively within the organisation.	*This requirement is not specific to this survey.*
Ensure that all research involving participants for whom they are responsible has ethical approval and that someone with the authority to do so has given written permission on behalf of the care organisation before each study begins.	*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.*
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.	*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.*

Research Governance Framework	The Healthcare Commission patient surveys
Ensure that written agreements are in place regarding responsibilities for all research involving an external partner, funder and/or sponsor, including agreement with the University or other employer in relation to student supervision.	*A detailed guidance is issued to all the trusts, which spells out the responsibilities of all parties involved in the survey.*
Maintain the necessary links with clinical governance and/or best value processes.	*The guidance notes very strongly recommend the trusts to maintain these links and follow best practice evidence.*
Ensure that, whenever they are to interact with individuals in a way, which has a direct bearing on the quality of their care, non-NHS employed researchers hold honorary NHS contracts and there is clear accountability and understanding of responsibilities.[1]	*In situations where trusts opt to use the services of an external contractor to draw the sample for the survey, the contractor is required to enter into an honorary contract with the trust. These procedures are specifically detailed in the guidance notes.*
Put and keep in place systems to identify and learn from errors and failures.	*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.*
Put and keep in place systems to process, address and learn lessons from complaints arising from any research work being undertaken through or within the organisation.	*This requirement is not specific to this survey.*
Ensure that significant lessons learnt from complaints and from internal enquiries are communicated to funders, sponsors and other partners.	*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 NHS Patient Survey Advice Centre who are commissioned by the Healthcare Commission to co-ordinate the patient surveys.*

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

Research Governance Framework	The Healthcare Commission patient surveys
Ensure that any research-related adverse events are included in reports to the National Patient Safety Agency in line with the standard procedures of the organisation; or to the systems for adverse events reporting in social care.	*Not applicable to the patient survey. Patient safety is not compromised, this being a postal survey.*
Permit and assist with any monitoring, auditing or inspection required by relevant authorities.	*The results of the surveys are used for performance monitoring and national star rating mechanisms*

7 Collecting data from non-English-speaking populations

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

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

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

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

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

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

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

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

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

8 Timetable

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

Timetable

Week	Task	See Section
0	**Inform Survey Advice Centre about who is carrying out the survey (by 30 July 2004 at latest).**	3
1	**Draw sample of patients to be included in the survey**	9
1	**Submit sample list to NSTS to check for deceased patients**	9.5
1	**If using an approved contractor, supply them with trust headed paper and a signature of a senior executive and, if appropriate, ensure that the honorary contract is signed**	5.2, 5.3 & 12.2
2	**Decide on questions to be included in the survey (i.e. select from question bank or use the Core Emergency Survey)**	11
2	Print questionnaires and covering letters.	12.1 & 12.2
2	Ensure you have enough envelopes, return envelopes and labels	12.3 to 12.6
2	Set up FREEPOST address and FREEPHONE line	13.1 & 13.2
2	Establish system for responding to telephone enquiries	13.2
3	Establish system for booking in questionnaires	13.5
3	Send out first questionnaires	13.4
3 - 8	**Stick labels on pre-packed numbered questionnaires supplied by approved contractor** (if NOT using honorary contract)	
3-12	Continue to respond to telephone enquiries	
3-12	Continue to book in returned questionnaires	
3-12	Enter data	14
4	**Check your trust's own records again for any patient deaths**	9.7
5-6	Send out first reminders to non-responders	0
5-6	Be prepared for a small peak in telephone calls as first reminders received	13.2
7	**Check your trust's own records again for any patient deaths**	9.7
8	Send out second reminders to non-responders	0
11	Complete data entry	
11	Check data for errors ***Very Important***	14.4
12	Send data to Survey Advice Centre (by 5 November 2004 at latest)	14.5
12	Begin analysing trust's results and writing report	15 & 16

9 Compiling a list of patients

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

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

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

9.1 Compile a full list of patient attendances in 1 month

- Select the month of Emergency Department attendances that your survey will cover. Depending on when you start, this should be **either** June 2004 **or** July 2004 **or** August 2004.

- Compile a full list of all patient **attendances** at all Emergency Departments (A&E /Casualty) **at all sites** in your trust during one month.

- This is a list of **attendances/visits**, rather than a list of patients, so some patients will appear in the list more than once, but that does not matter at this stage.

What to leave out

Attendances by the following patients should be removed from the list:

- Any attendances at **Minor Injuries Units**

- Any patients who were admitted to hospital via **Medical or Surgical Admissions Units** and therefore have not visited the Emergency Department

- Children **under 16** at the date of their arrival at the hospital

- Any patients who are known to be **current inpatients**

- Patients who are known to have **died**

- Patients who do not have a **known UK address**

- Planned attendances at **outpatient clinics which are run within the Emergency Department** (such as fracture clinics)

9.2 Data fields to include in the list of attendances

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

- Patient Record Number [2]
- Title (Mr, Mrs, Ms, etc.)
- Initials (or First name)
- Surname
- Address Fields [3]
- Postcode
- Year of birth
- Gender
- Ethnic category [4]
- Date of arrival at the Emergency Department
- Survey unit – e.g. hospital site [5] - **Optional**
- Any other details required by the NHS Strategic Tracing Service (NSTS). Wherever possible, this should include the NHS number. [6]

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[2] This field will be a series of sequential numbers (for example, 1001 through to 1850 but make sure it is a different number range than that used in your Outpatients Survey). The patient record number will be included on address labels and on questionnaires. Later, when questionnaires are returned (whether completed or returned undelivered), you (or the Approved Survey Contractor) will be able to use these numbers to monitor which patients have returned their questionnaires and to identify any non-responders, who will need to be sent reminders.

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

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

[5] This is optional, but it might be useful information if you later want to compare hospital sites or units within the trust. However, you should discuss this fully with the approved survey contractor, who will advise on the minimum sample size required for such comparisons.

[6] The NHS number can give more accurate matching, especially if addresses are incomplete. It is advisable to liaise with the registered NSTS batch trace user (if this is not the same person who creates the sample list) to ensure that all the required fields are included in the list of service users (see Section 9.5 for more details on using the NSTS).

9.3 Taking a sample of patients to send to the tracing service

It is likely that your full list will include thousands of attendances, but you will need to send questionnaires to only **850** patients.

Note: You are aiming for **a response rate of at least 50%** (but many trusts will achieve a much higher response rate than that), which means that you should have about 450 completed questionnaires if you send questionnaires to 850 patients. You will be able to maximise your response rate by following this guidance carefully. 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 Survey Advice Centre will only be able to accept responses from the 850 patients in your list that have been correctly sampled.

The first step is to take a random sample of patients to send to the NSTS (National Strategic Tracing Service). It is likely that some of your patients will have died, so it is advisable to select an initial sample of 900 patients, which will later be reduced to 850. The procedure for doing this is as follows:

1. Put the list of **all** eligible attendances in your chosen month (i.e. June, July OR August 2004) into an electronic file in a programme that allows sorting by columns (for example, Microsoft Excel or Access).

2. Sort the list by patients' **surnames**, and then by **year of birth** (N.B. Ensure that you select all columns before sorting in Excel, otherwise the patient details will get mixed up). Sorting should ensure that all attendances by the same patients come next to each other in the list.

3. Count the total number of attendances in the chosen month.

4. Calculate the sampling interval you will need to extract 900 patients from the total number of attendances, in order to select your pre-tracing sample of 900 patients. (See example below.)

Example

Number of Emergency Department attendances at your trust in one month = 26,500

Sampling interval (*i*) = 26,500 ÷ 900 = **29.4**

5. Round **down** your interval to the nearest whole number to give you a value which we will call ***i*** (in this example, *i* would be **29**.)

6. Create a new data column in your patient file (call this column '**interval**). Fill this column with a repeating series of numbers, starting with 1 in the first row and then numbering each record consecutively through to **29,** then starting again at 1 through to 29, and so on until you get to the bottom of the list. (Remember to use your own value of ***i***.)

7. Choose a random number, between 1 and the value of *i* (29). Let's assume the random number is **14** in this example.

8. The sample will be all those records with a value of **14** in the 'interval' column (remember to use your own random number). Delete all records with values that are **not equal** to **14**.

   If you are using Excel, it might be easiest to sort the data by the new column 'interval' and then delete all the rows that **do not** have **14** in the interval column. (N.B. Ensure that you select all the columns before sorting in Excel, otherwise the patient details will get mixed up).

9. This will give you a list of patients consisting of every i^{th} record from the original list. This should be at least 900 records. Save this sample into a new file (keeping the initial sample list in another file, in case you need to return to it later).

9.4 Check the sample list

Once you have compiled your list of 900 patients, it is important to carry out a few final checks before sending the data to the NSTS:

- **Duplications.** You should check your list to make sure patients' names do not appear more than once, and you should remove any duplicated names. [7]

- **Postal addresses.** Check again that there are no addresses that are outside the UK.

- **Patient ages.** Check again that all patients are aged 16 or over.

- **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.

[7] This sampling procedure minimises the chances that patients will be duplicated in your final list. That is, in the above example, a patient could only be selected twice if they had 29 or more attendances to the Emergency Department in 1 month. However, if your trust has particularly small numbers of attendances, you are more likely to have some duplicated patients.

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

- **Deceased patients.** Check again that the patients were all discharged alive. Also check that the trust does not have a record of a patient's death from a subsequent admission or visit to hospital.

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

Before sending out the questionnaires, the list of patients will also have to be checked for any deceased patients by the NHS Strategic Tracing Service (NSTS). The NSTS contact details are as follows:

Help desk telephone number: 0121 788 4001

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

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

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

Note

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

9.6 Check the trust's records for patient deaths

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

Note from SchlumbergerSema (NSTS Partner)

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

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

The full details are given in the new instruction manual:

SchlumbergerSema NHS Patient Survey File Creation Guide

This is available on the NHSSurveys website.

The basic requirements are:

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

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

9.7 When patient file is returned from the NSTS

If you have more than 850 patients remaining in your list

When your patient list comes back from NSTS, if it is still greater than 850, you will need to delete a random selection of records to from the file to reduce it to 850 records. To do this:

1. Calculate how many patients you need to remove by subtracting 850 from the number in your list. For example if your list has 872 patients, you will need to remove 22 patients.

2. Calculate your sampling interval. In this example, it would be:

$$872/22 = \underline{39.6}$$

3. Note that an important difference between this random sampling and the previous procedure you used to select the original sample of 900 is that, at this stage, you are now selecting patients to *exclude*, rather than to *include*.

4. Now round *up* your sampling interval to the nearest whole number, to give you a value which we will call ***j***. (In this example *j* would be **40**.)

5. Create a new data column in your patient file (call this column '**interval**). Fill this column with a repeating series of numbers, starting with 1 in the first row and then numbering each record consecutively through to **40,** then starting again at 1 through to 40, and so on until you get to the bottom of the list. (Remember to use your own value of ***j***.)

6. Choose a random number, between 1 and the value of *j* (40). Let's assume the random number is **23** in this example.

7. The patients that will be excluded from the sample will be all those records with a value of **23** in the 'interval' column (remember to use your own random number).

8. Delete all records with values that are **equal** to **23**. If you are using Excel, it might be easiest to sort the data by the new column 'interval' and then delete all the rows with **23** in the interval column. (N.B. Ensure that you select all the columns before sorting in Excel, otherwise the patient details will get mixed up).

9. This will give you a list of 850 patients. Save this as the patient survey sample.

Too few patients in the list

If you have fewer than 850 patients in your list at this stage, please contact the Advice Centre.

You should not exclude patients just because it was not possible for the NSTS to match them on their records. If you did this, you would bias the sample.

9.8 Organise the patient information into the sample file

Once the file is returned from the NSTS, and you have reduced it to 850 patients, you need to keep the patient information in an electronic spreadsheet or database file, where you can record which questionnaires have been returned. At the end of the survey process, you will be asked to send an anonymised version of this information to the Patient Survey Advice Centre. You will also need to keep this file until 31st December 2004, in case your trust is included in the non-response follow up survey to be carried out by researchers at BMRB.

Firstly, you will need to add three new columns:

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

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

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

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

Table 1 – Sample Excel file of patient details

Patient Record Number	Title	Initials	Surname	Address1		Postcode	*Year of birth*	*Gender*	*Ethnic Category*	*Day of month of attendance*	*Month of attendance*	*Year of attendance*	*Outcome*	Comments
1001	Mrs	AM	Abbot				1925	2	1	1	7	2004	3	Informed Patient died
1002	Mr	EC	Ahmed				1937	1	3	2	7	2004	1	
1849	Miss	K	Yoo				1965	2	5	31	7	2004		
1850	Ms	F	Young				1941	2	1	31	7	2004	1	

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

- Make sure the number range you use for the **Patient Record Numbers** is different from that used for your Outpatients Survey.

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

- The **Year of Birth** is included in the form NNNN. Only patients aged over 16 should be included in the sample.

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

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

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

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

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

  Note that these codes have changed since the last survey.

  The outcome column is left blank at first if the survey has not been returned, so it can be seen that Miss Yoo has not yet returned her questionnaire; Mr Ahmed and Ms Young have returned theirs; and Mrs Abbott has died since the survey started.

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

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

9.9 Sharing the Patient Sample file with an approved contractor

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

9.10 Using the patient sample file

This file has two purposes:

1. It will be used to keep a record of which patients have returned questionnaires so that reminders can be sent to them.
2. The anonymous data in this file (i.e. all the data **except** patient name and address information) will form part of the file that you will submit to the Advice Centre when the survey is completed.

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

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

9.11 Comparing departments or hospitals within your trust

If you want to go beyond the minimum requirements, you could use the NHS Trust Survey programme as an opportunity to gather data about different hospitals or units within your trust. You could extend the number of patients you target, and ensure that you target sufficient numbers from each of the units you want to compare so that you can get enough responses to make comparisons. However, before deciding to do this, it is essential that you read the sampling guidance in this section, and that you do not mix up your standard survey sample with any additional patients.

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

Important note

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

10 Publicising the survey

The following measures will help to increase response rates and reduce the number of questions and complaints 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 managers 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 managers 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.

11 The Emergency Survey Core Questions and question bank

Each trust must include in their survey at least the 49 Core Emergency Survey questions. There is a pre-designed Core Questionnaire on the NHSSurveys website, which includes only these questions. In addition, by using the "Create your own survey" option on the website, you can include supplementary questions from a bank of validated questions. These questions will be inserted into the appropriate places in the questionnaire, and the document will then be generated in .pdf format, ready for printing.

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

In summary, there are three options for carrying out the NHS Emergency department surveys:

1. The **Core Emergency Survey**, which comprises 49 core questions.

2. The **Enhanced Survey**, which includes all of the 49 Core Emergency Survey questions, with an additional bank of validated questions.

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

If you design your own questions, it is essential that survey questions be **carefully designed and properly tested** before they are included in a questionnaire.

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

The surveys can be accessed from the NHSSurveys website.

11.1 The Core Emergency Survey

The Core Emergency Survey consists of 49 questions on 8 pages. These 49 questions cover the issues that have been found to be most important to patients and the questions that trusts said they found to be the most useful, and they must be included in your survey. The front page of the survey explains the purpose of the survey and gives instructions on how to fill it in. In the following pages, the survey questions are divided into sections that broadly follow the patient's experience.

11.2 Using the question bank

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

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

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

11.3 The Customised Survey

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

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

12 Materials

12.1 Printing questionnaires

Number of pages

It is practical to ensure that the number of pages in a questionnaire is a multiple of four so that sheets can be printed double-sided on A3 paper and folded to make an A4 booklet, stapled in the middle. If pages are stapled at the corner, there is a greater chance that some pages will become detached and get lost. The Core Questionnaire, available in pdf format on the NHSSurveys website, is designed to fit on to 8 sides of A4 paper.

Number of questionnaires

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

12.2 Trust headed paper

You will need trust headed paper for covering letters for the first and third mailing. (A reminder slip is used for the second mailing.) Therefore, depending on your response to the initial mailings, you should need approximately 1,500 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.

12.3 Other items

You will also need:

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

12.4 First mailing

You will need 850 of each of the following items:

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

12.5 Second mailing (first reminder)

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

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

12.6 Third mailing (second reminder)

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

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

13 Implementing the survey-practicalities

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

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

13.1 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.

13.2 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. You might want to set up a FREEPHONE line for this purpose. 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.

Common questions and comments

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

Patients should be advised to refer only to their most recent visit.

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.

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 will be a true reflection of the patients' views.

The person to whom the questionnaire is addressed has died.

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

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

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

I do not wish to participate in this survey.

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

Making a record of the calls

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

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

13.3 Covering letters

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

Covering letter for first mailing

To be printed on trust headed paper. Text in square brackets to be edited.

Date

Dear patient

Emergency Department (A&E / Casualty) survey

We are inviting you to take part in a survey of patients who have recently visited the Emergency Department (A&E/Casualty) at [Hospital A] [or Hospital B].

What is the purpose of the survey?

Your views are very important in helping us find out how well the emergency department[s] work[s] and how [they/it] can be improved. This is part of our commitment, outlined in the NHS Plan, to design a health service around the patient.

Why have I been chosen?

You are being invited to take part in this survey because you recently visited the Emergency Department. We are sending questionnaires to [850] randomly selected patients.

Do I have to take part?

No. Taking part in this survey is **voluntary**. If you choose not to take part it will not affect the care you receive from the NHS in any way. If you do not want to take part in the survey, or to answer some of the questions, you do not need to give us a reason.

What would I have to do?

If you decide to take part, please complete the questionnaire and return it in the FREEPOST envelope. No stamp is needed. The questionnaire should take around 20 minutes to complete.

If you do not wish to take part, please could you return the blank questionnaire in the FREEPOST envelope. If we do not hear from you in 2-3 weeks we may send you a reminder.

Will my taking part in this study be kept confidential?

Yes. You have been given a unique number so your name and address are not on the questionnaire. Information will not be passed on to doctors, nurses or other NHS health care staff in a way that allows you to be identified.

Who is organising the survey?

The survey is being carried out by researchers from [NHS Trust name /name of survey company], the Healthcare Commission and the NHS Surveys Advice Centre at Picker Institute Europe. The results will be presented in a form that does not allow any individual's answers to be identified. The anonymous survey findings will be analysed by the Advice Centre and the Healthcare Commission and be available on their website at [http://www.healthcarecommission.org.uk/NationalFindings/Surveys/fs/en].

Contact for further information

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

Thank you

Yours faithfully

[Chief Executive name]

Chief Executive

[NHS Trust Name]

13.4 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.

Questionnaire packs

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

- 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
- A covering letter
- A large envelope, labelled with the FREEPOST address on it.

These items should be packed into an envelope that has a return address on the outside. This should be the contact at the NHS Trust, or the Approved Contractor.

Postage

Note

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

Approved contractors – no honorary contract

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

Approved contractors – honorary contract

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

13.5 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 30 April 2005, but please **do not** send these to the Advice Centre.

Approved contractors

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

13.6 Sending out reminders

For results to be representative, it is essential to get a good response rate. The minimum response rate for this survey is 50%. In order to achieve this, you must send out two reminders to non-responders. **It is essential that you send out both reminders, even if you already have achieved the minimum 50% 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 to the tracing service for a further check before you send out reminders.

Approved contractors

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

First reminders

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

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

First reminder

Text in square brackets needs to be edited.

[Date]

[Name of NHS Trust]

Approximately three weeks ago we sent you a questionnaire about health care at [NHS Trust Name]. At the time of sending this note, we have not yet received your response.

Participation in the survey is voluntary, and if you choose not to take part it will not affect the care you receive from the NHS. However, **your views are important to us** so we would like to hear from you. (The return envelope you were sent with the questionnaire does not need a stamp.)

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

If you have any queries about the survey, please call our [FREEPHONE line /us] on [number] between [opening time] and [closing time], Monday to Friday.

Second reminders

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

1. A questionnaire numbered with the Patient Record Number. The number on the address label must match the number on the list of patient details
2. A covering letter
3. A large envelope, labelled with the FREEPOST address on it.

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

Covering letter for second reminder

To be printed on trust headed paper. Text in square brackets to be edited.

Date

Dear patient

Emergency Department (A&E / Casualty) survey

Enclosed is a copy of a patient survey about your visit to the Emergency Department (A&E/Casualty) of [Hospital A] or [Hospital B]. We originally sent the survey to you a few weeks ago. If you have already replied, please ignore this letter and accept our apologies.

What is the purpose of the survey?

Your views are very important in helping us find out how well the emergency department[s] work[s] and how [they/it] can be improved. This is part of our commitment, outlined in the NHS Plan, to design a health service around the patient.

Why have I been chosen?

You are being invited to take part in this survey because you recently visited the Emergency Department. We are sending questionnaires to [850] randomly selected patients.

Do I have to take part?

No. Taking part in this survey is voluntary. If you choose not to take part it will not affect the care you receive from the NHS in any way. If you do not want to take part in the survey, or to answer some of the questions, you do not need to give us a reason.

What would I have to do?

If you decide to take part, please complete the questionnaire and return it in the FREEPOST envelope. No stamp is needed. The questionnaire should take around 20 minutes to complete.

If you do not wish to take part, please could you return the blank questionnaire in the FREEPOST envelope.

Will my taking part in this study be kept confidential?

Yes. You have been given a unique number so your name and address are not on the questionnaire. Information will not be passed on to doctors, nurses or other NHS health care staff in a way that allows you to be identified.

Who is organising the survey?

The survey is being carried out by researchers from [NHS Trust name /name of survey company], the Healthcare Commission and the NHS Surveys Advice Centre at Picker Institute Europe. The results will be presented in a form which does not allow any individual's answers to be identified. The anonymous survey findings will be analysed by the Advice Centre and the Healthcare Commission and be available on their website at [http://www.healthcarecommission.org.uk/NationalFindings/Surveys/fs/en].

Contact for further information

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

Thank you

Yours faithfully

[Chief Executive name]
Chief Executive
[NHS Trust Name]

14 Entering data

The data must be submitted to the Advice Centre in the appropriate format by the deadline on 5 November 2004. If an Approved Survey Contractor is used, they will be responsible for all of the data entry and checking, and when the survey is completed they should submit the data to the Advice Centre in the correct format and supply the trust with an anonymised data set.

14.1 Entering and coding data from the Core Emergency Survey

The data should be entered into a pre-designed Excel file on 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 (.). [8]
- 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 Advice Centre, please save only the first sheet as a **worksheet**, rather than saving the whole file as a workbook. (This saves disk space.)

14.2 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

[8] 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 (.).

14.3 Adapting data file for sending data to the Advice Centre

You will need to send the data from the 49 compulsory Core Emergency Survey questions to the Advice Centre. To do this, you will need to transfer those columns of data that cover the responses to those 49 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 Emergency Survey. They also include the wordings of the 49 Core Emergency Survey questions so that you can match them up. It is essential that you check carefully that the columns of data you select from your larger data set correspond to the 49 Core Emergency Survey questions.

14.4 Checking the data for errors

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

2. Are all the data entries valid responses for that question? For example, if a question allows three response options: "1", "2" or "3", check that your data do not include any other numbers. If out-of-range numbers are found, go back to the original questionnaire and check those responses.

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

14.5 Submitting data to the Patient Survey Advice Centre

The data from the core questions of the Emergency Department Survey must be submitted to the NHS Patient Survey Advice Centre as one anonymised Excel file that includes information about the patient sample and responses.

File format

- Microsoft Excel Worksheet (*not* Workbook). Any version of Excel is acceptable.
- File name should be in the form <NHSTrustName>_Emergency2005.xls
- One row of data for each patient in the sample.
- One column of data for each item of patient information or response.
- Missing data should be left blank or coded as a full stop (.). [9]

[9] 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 2 shows the information that must be provided for each of the 850 patients in the original sample.

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

Field	Format	Data codes	Comments
Patient Record Number	NNNN		The unique serial number allocated to each patient by the trust or Approved Survey Contractor administering the survey
Year of birth	NNNN		
Gender	N	1 = male 2 = female	If gender is not known or unspecified, this field should be left blank or coded as a full stop (.).
Ethnic category	N	1 = White 2 = Mixed 3 = Asian or Asian British 4 = Black or Black British 5 = Chinese 6 = Other ethnic category	Ethnic category should be included if the information is available
Day of attendance	N or NN	Format this field as a number, not a date	For example, if the patient attended the department on 16th July 2004, this column should read 16.
Month of attendance	N	Format this field as a number, not a date	For example, if the patient attended the department on 16th July 2004, this column should read 7.
Year of attendance	NNNN	Format this field as a number, not a date	For example, if the patient attended the department on 16th July 2004, this column should read 2004.
Outcome of sending questionnaire	N	1 = Returned useable questionnaire 2 = Returned undelivered by the mail service or patient moved house 3 = Patient died 4 = Patient reported too ill to complete questionnaire, opted out or returned blank questionnaire 5 = Patient was not eligible to fill in questionnaire 6 = Questionnaire not returned (reason not known)	Outcome of sending questionnaire Remember to fill in all the blank cells with 6s when the survey is complete.
Responses to each of the 49 Core questions	N or NN or NNNN		Each column must be clearly headed with the Core Questionnaire question number. Data should be coded using the numbers next to the response boxes on the printed surveys. There is no need to send the comments to the Advice Centre.

N.B. To comply with the Data Protection Act, name and address details must not be sent to the Advice Centre.

Table 3 is an example of the columns of data to be included in the file. Your file should have 850 rows (one for each patient included in your sample). You will notice that there are several blank cells in the response section of the file. This is because the file includes a row for every patient in the sample, but you will only have responses from about 50% of the patients (that is, those who have returned a completed questionnaire, and who will therefore have an outcome code "1").

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

Patient Sample Information								*Patient Response Information*							
Patient Record Number	*Year of birth*	*Gender*	*Ethnic Group*	*Day of month of attendance*	*Month of attendance*	*Year of attendance*	*Outcome*	*Q1*	*Q2*	*Q3*	--	*Q46*	*Q47*	*Q48*	*Q49*
1001	1934	2	1	1	7	2004	3								
1002	1970	1	3	2	7	2004	1	1	1	5		2	2		8
1003	1965	2	1	2	7	2004	6								
1004	1935	2	1	3	7	2004	1	2				3	2		1
1005	1929	2	1	3	7	2004	1	1	3	1		4	2		1
1006	1923	1	4	3	7	2004	2								
1849	1950	2	5	31	7	2004	6								
1850	1946	2	1	31	7	2004	1	1				3	1	2	1

Additional information

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

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

Delivery

Trust survey data may be sent on floppy disc or by e-mail:

Postal address:

Emergency Survey
Advice 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

Date

The data must be supplied by 5 November 2004.

14.6 Checklist

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

Check	Done? Please *initial*
1. Check that your **file name** follows the naming convention: <NHSTrustName>_Emergency2005.xls)	
2. Check that you have saved the data sheet only as an Excel **worksheet**, rather than a workbook. (The frequency and percentage counts on the other pages of the workbook on the website are intended for your use only.)	
3. Send data only for the **850 patients** sampled from your trust in the chosen month.	
4. Check that all **data are correct**, and that all values are in range.	
5. Check that you have included data columns for **all 49 core questions**.	
6. Check that you have **not** included any columns of optional questions.	
7. Check that all the data are in **numeric format** only.	
8. To comply with Data Protection regulations, any **patient name and address details** must be removed before the file is sent to the Survey Advice Centre.	
9. Remove any **passwords**.	
10. Include **two paper copies** of the questionnaire you used.	
11. Include **two paper copies** of the covering letters you used for the first mailing, the second mailing and the third mailing.	
12. Include **telephone and e-mail contact details of 2 people** who will be available to respond to any queries about the data.	
13. **Check again** that all data are correct, and that all values are in range!	
14. Remember to **keep a copy of the patient sample information until 31st December 2004**, in case your trust is included in the non-response follow-up survey to be carried out by researchers at BMRB.	

Very important

It is essential that these checks are carried out thoroughly. The Advice Centre is not obliged to make any corrections to data supplied by trusts or approved contractors. If incorrect data are submitted, it is likely that the data will be considered unreliable and will not be used by the Healthcare Commission in your trust's performance ratings, and those indicators will be set to a minimum. We cannot accept re-submissions of data after the deadline.

15 Making sense of the data

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

15.1 Using the NHSSurveys website to look at results

Once you have entered the data from the core questions into the Excel file on the website, the counts and percentages of responses to each of the 49 core questions are automatically computed and displayed on other sheets of the Excel workbook, which correspond to sections of the Emergency Core Questionnaire. For each question, the numbers and percentages of respondents who gave each answer is shown. The number of missing responses will also be shown, as long as you have coded missing responses on the data sheet as a full stop (.).

15.2 Suggestions on data analysis

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

Use the data to help pinpoint problems

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

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

"Drill down" into the data

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

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

Group similar questions together to provide summary analysis

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

- Link questions that cover similar topics or processes
- Combine several questions into a single composite measure (by averaging problem scores, 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 problem score). If tests show that the differences between two groups are not statistically significant, you should view the patterns of responses as only suggestive.

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

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

Use patient feedback data with other data

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

16 Reporting results

16.1 Prioritising your report

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

Rank problems by their magnitude

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

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 facilitate networking among units or departments and sharing information about effective practices. Internal competitiveness may also fuel improvement efforts.

Compare results over time

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

Comparison with predefined goals

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

Correlation with overall measures

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. (It is important to remember that the distribution of survey responses is unlikely to be *normal* in the statistical sense, and so rank-based correlation methods are more appropriate e.g. Spearman's rank correlation coefficient.)

Predictive value on overall measures (regression analysis)

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

Ease of action

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

Areas of excellence

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

16.2 Writing the report

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

Gear the format to the audience

- Use brief, succinct summaries for executive audiences.
- Use comprehensive summaries for those who will implement improvements. They will help achieve buy-in and generate action.
- A resource booklet or data diskettes with full details may be important when problems arise, or if researchers have questions.

Use graphics

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

Keep the format succinct and consistent

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

Emphasise priorities clearly

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

17 Using results for quality improvement

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

17.1 Prepare carefully

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

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

17.2 Dissemination of survey results

Engage key stakeholders

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

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

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

Spread the Word

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

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

Promote understanding

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

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

17.3 Identify key "change agents"

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

17.4 Prioritising areas for improvement

Compare with other trusts

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 departments within your trust

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

Identify where patients report most room for improvement

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

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

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

Identify problems surrounding particular aspects of the patient experience

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

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

17.5 Develop an action plan

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

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

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

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

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

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

18 Appendix – Designing and testing new questions

This section gives guidance on designing your own questions and putting them into a survey. As noted in Section 11, the skill and effort required to design survey questions and put them together into a workable format is very often underestimated. For this reason, we **strongly recommend** that, unless you have considerable experience in questionnaire design, you should use only the standard pre-tested questions available on the NHSSurveys website.

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

18.1 Designing good questions

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

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

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

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

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

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

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

- **Use single subject questions whenever possible**

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

- **Avoid leading or biased questions**

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

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

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

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

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

  For example,

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

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

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

18.2 Layout of the questionnaire

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

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

- **Ensure that appropriate filters are included**

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

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

Table 4 - Comparison of types of questions

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

18.3 Examples of survey questions

Report question

Q. Were you given enough information about any side-effects the medicine might have?

1 ☐ **Yes**, enough information

2 ☐ **Some**, but I would have liked more

3 ☐ I got **no information**, but I wanted some

4 ☐ I **did not want/need** any information

5 ☐ Don't know/ Can't say

Rating question

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

☐ Poor

☐ Fair

☐ Good

☐ Very Good

☐ Excellent

Open-ended question

What can we do to improve our services?

_____

_____

_____

_____

_____

_____

18.4 Pre-testing survey questions

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

Why bother with pre-testing?

Pre-testing is essential in order to:

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

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

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

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

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

Selecting patients for the pre-test

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

Suggestions for conducting a pre-test

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

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

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

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

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

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

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

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

    - *Did response scales put you off?*

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

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

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

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

Patient survey programme 2004/2005

Emergency department: key findings

This information is available in other formats and languages on request. Please telephone 0845 601 3012.

ISBN: 1-84562-013-5

The emergency survey 2004/2005 was designed, developed and coordinated by the NHS survey advice centre at Picker Institute Europe

What is the Healthcare Commission?

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

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

- replaces the work of the Commission for Health Improvement (CHI), which closed on March 31st 2004
- takes over the private and voluntary healthcare functions of the National Care Standards Commission, which also ceased to exist on March 31st 2004
- picks up the elements of the Audit Commission's work which relate to efficiency, effectiveness and economy of healthcare

In taking over the functions of CHI, the Healthcare Commission now has responsibility for the programme of national patient surveys initiated by CHI.

Contents

Section 1

Introduction

Asking patients what they think about the care and treatment they have received is an important step towards improving the quality of care, and to ensuring that local health services are meeting patients' needs. A useful way of doing this is by carrying out surveys of patients who have recently used the health service.

During 2004/2005 the Healthcare Commission is carrying out four national surveys asking patients across England about their experiences of emergency departments, outpatients, mental health and primary care services. The NHS Surveys Advice Centre at Picker Institute Europe have developed the questionnaires and methodology.

Our programme of surveys of patients is aligned with our new approach to assessment, outlined in the consultation document, *Assessment for improvement – Our approach* (available on the Healthcare Commission website). We are required to carry out an annual review of each NHS organisation and will assess performance in relation to the Government's new core and developmental healthcare standards. Part of this is looking at what matters most to patients, carers and members of the public.

The first emergency department survey was published in 2003[1]. This report summarises the key findings of the 2004/2005 emergency department survey and highlights differences with the 2003 results.

The survey results show that overall waiting times in emergency departments have improved and that patients' confidence in doctors and nurses remains high. However, there are concerns about cleanliness, and information given to patients when they leave the emergency department needs to improve.

The results of the survey and the experiences of patients in each NHS trust are available in detailed reports and can be found on the Healthcare Commission website (http://www.healthcarecommission.org.uk/PatientSurveyAandE2004).

[1] Accident and emergency (A&E) patient survey 2003. Commission for Health Improvement, London.

1.1 Who took part in the survey?

This survey was carried out in all 153 acute NHS trusts in England that have an emergency department that treats adults. Each trust identified a list of 850 randomly selected patients who had attended its emergency department during June, July or August 2004. Patients were eligible if they were aged 16 years or over. People who attended minor injuries units and medical or surgical admissions units were excluded from taking part in the survey.

The sampled patients were sent a postal questionnaire with a covering letter and up to two reminders were sent to those who did not respond.

Questionnaires were sent to 129,948 patients and completed questionnaires were received from 55,339 patients. This represents a response rate of 44%, after undelivered questionnaires and deceased patients had been accounted for. Response rates varied among trusts, from 26% to 59%. This compares to a response rate of 46% for the 2003 survey, with response rates varying among trusts from 26% to 61%.

The 2003 and 2004/2005 survey results were compared on all of the 39 questions that were directly comparable. That is, comparisons were made on those questions that were unchanged between the two surveys, or for which response options could be matched up in a way that made them comparable. All differences that are noted in this report are statistically significant.

The questionnaire was designed to reflect the issues that patients have told us matter to them. It was largely composed of closed questions, but the final section invited people to comment in their own words on things that were particularly good about their care and things that could be improved. The quotes in colour are drawn from these comments.

Of all those patients who returned completed questionnaires:

- 54% were women
- 26% were aged 16 to 35 years, 24% were aged 36 to 50 years, 22% were aged 51 to 65 years and 28% were aged 66 or over
- 93% were White, 3% Asian or Asian British, 2% Black or Black British and 1% were of mixed race, Chinese or other ethnic groups
- 61% of patients rated their own health as between good and excellent in the previous four weeks, and 39% very poor, poor or fair

It is important to compare the demographic characteristics of the respondents and those who did not respond to the survey, as the respondents may not be representative of all patients who use an NHS trust. The highest response rate (65%) came from male patients aged 66 years or over. The second highest response rate, at 64%, was from females in the 51 to 65 years old age group. Response rates were lowest for men aged 16 to 35 at 23%

Section 2
Arriving at the emergency department

Arriving at the emergency department

Emergency departments provide a range of services, from treating people with major injuries, admitting those who have unexpectedly fallen ill to hospital, and seeing to people with less serious health problems.

2.1 Getting there
Compared to the results of the 2003 survey, fewer respondents to the 2004/2005 survey had used an ambulance to get to the emergency department (28% in 2004/2005 compared with 31% in 2003). A higher percentage of patients used a car to get to the emergency department in 2004/2005 than in 2003 (an increase of 3%).

2.2 Receptionists
Twenty three per cent of all patients said the courtesy of receptionist was good, 9% rated it as fair and 3% said it was either poor or very poor. Twenty nine per cent rated the courtesy of the emergency department receptionist as excellent, and 36% as very good.

"Reception knew who I was when I walked in the next day for an appointment and called me by my first name. All staff made me feel valued and not just a number, and made me feel at ease."

"Reception could be improved. The person I saw was quite abrupt and 'matter of fact'. Patients attending A&E departments need reassurance and friendliness, particularly if they are in pain. A smile works wonders."

2.3 Waiting
On arrival at the emergency department the 2004/2005 survey showed that:

- 47% of patients had to wait up to 15 minutes before they first spoke to a doctor or nurse
- 29% of patients had to wait between 16 and 30 minutes
- 14% of patients had to wait between 31 and 60 minutes
- 10% of patients had to wait over an hour before they first spoke to a doctor or nurse

"It took far less time than I anticipated and everyone was being seen, helped and spoken to (about 20 patients, including one who was disruptive). I was very satisfied. Thank you."

In the 2004/2005 survey the majority of patients thought that the order in which they were seen was fair (90%). This is an improvement on the 2003 results, which showed that 87% of patients thought that the order in which they were seen was fair.

"On arrival, the department was crowded and I anticipated a long wait. However, when the extent of my injury was apparent and it was obvious I was in severe pain, I received prompt attention."

Section 2
Arriving at the emergency department

Nationally, patients had to wait a shorter time to be examined by a doctor or nurse practitioner in 2004/2005 than in 2003:

- 75% of patients reported that they were examined by a doctor or nurse practitioner within one hour, compared to 66% in 2003
- 22% of patients said they waited between one and four hours to be examined, compared to 27% in 2003
- 3% of patients said they had to wait over four hours before being examined by a doctor or nurse practitioner, compared to 7% in 2003

For patients who had to wait, 56% were not told how long they would have to wait to be examined. This represents a decrease of 2% since the 2003 survey.

Compared with the 2003 survey, fewer patients in 2004/2005 reported that they had to wait longer than they had been told, a decrease from 13% in 2003 to 10% in 2004/2005. In 2004/2005 more patients (16%) said that they had to wait for less time than they had been told, and 2% more patients reported that they had to wait as long as they had been told.

"Keeping patients informed is very much appreciated. To be met by polite and courteous staff costs nothing but makes all the difference."

"I think getting seen to should be a lot quicker and nurses should check up on the patient more frequently to see how they are feeling and to tell you how much longer you will have to wait."

The NHS Plan (2000)[2] set a target that: "By 2004 no-one should be waiting more than four hours in accident and emergency from arrival to admission, transfer or discharge." In 2003 the Department of Health set a standard that 98% of patients should not be waiting more than four hours in accident and emergency from arrival to admission, transfer or discharge. The scope of this survey means that waiting times reported by patients cannot be directly compared with waiting time data from NHS trusts. However, it provides the opportunity to assess trends overtime.

Overall, patients' visits to the emergency department were shorter in 2004/2005.

- 77% of patients reported that they stayed in the emergency department for no more than four hours, compared with 69% in 2003
- 18% of patients reported that they stayed between four and eight hours, whereas in 2003 this figure was 22%
- the percentage of patients who reported they stayed longer than eight hours fell from 9% in 2003 to 6% in 2004

[2] The NHS Plan: a plan for investment, a plan for reform. 2000. Department of Health.

Section 3
Doctors and nurses

Doctors and nurses

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

3.1 Answers to questions

The 2004/2005 emergency department survey showed that 66% of patients felt that they definitely had enough time to discuss their health or medical problem with the doctor or nurse. This is an increase of 4% since 2003. Similarly, the 2004/2005 survey found that more patients felt that they always got an explanation about their condition and treatment from a doctor or a nurse that they could understand (67% compared with 65% in 2003).

Nearly three quarters (74%) of patients felt that they had definitely been listened to by the doctors and nurses when they had something to say, and 23% thought they had been listened to to some extent. This indicates a slight improvement compared to the 2003 survey results, which showed 73% of patients felt that they were definitely listened to by the doctors and nurses.

"The doctor was very thorough. He explained everything very clearly and helped me to understand what had happened."

"When doctors have seen you, you feel that they do not sometimes listen properly and you feel that you are wasting your time even going to the hospital. Even though the doctor knows best and you put your faith in them."

Just over half (51%) of the respondents with anxieties and fears felt that they had been completely able to discuss their concerns with a doctor or nurse, 32% had discussed them to some extent and 16% did not feel able to discuss their anxieties and fears. Compared with the 2003 survey, this represents a 2% increase in the proportion of patients who felt that they were able to discuss their concerns completely.

"A full explanation was given to me by both the doctor and sister prior to any procedure taking place. This ensured I was relaxed at all times."

3.2 Confidence and trust

Patients' confidence and trust in staff partly reflects their perception of staff's knowledge and competence. This can include the staff's knowledge of their condition or of the treatment needed.

Responses to questions relating to patients' confidence and trust in staff were similar to those in 2003. Seventy three per cent of patients who saw a doctor or nurse had complete confidence and trust in the doctors and nurses examining them, and 22% felt that they only had this to some extent. The remaining 5% of patients did not have any confidence and trust in the doctors and nurses.

Slightly fewer patients in 2004/2005 felt that all doctors and nurses knew enough about their condition or treatment (1% decrease) and more patients in 2004/2005 thought that most staff knew enough (1% increase). Seventeen per cent of respondents said that only some staff knew enough or that none of the staff knew enough. This figure has not changed since 2003.

"The nurse's prognosis was very helpful and thorough; I was very impressed with her knowledge and care."

"Communication skills of the doctor were poor, leaving me feeling unsure of his ability to diagnose my problem. He may have known what he was doing but didn't inspire confidence."

Section 3
Doctors and nurses

3.3 Acknowledging patients

Eleven per cent of patients felt that doctors and nurses had talked in front of them as if they were not there to some extent, and 6% reported that this definitely happened. There has been no change in these figures since the 2003 survey.

"As an elderly person, it was lovely to have all staff, even cleaners, show you such respect."

An important way of demonstrating respect is by introducing yourself. Sixty one per cent of respondents said that all the staff treating and assessing them introduced themselves. However 39% of patients felt that only some, very few or none of the staff introduced themselves.

"Someone came over and did a diabetes check and took my blood pressure. They were not in uniform and had no ID card and they did not introduce themselves. I was not sure if it was a patient pretending to be a nurse or not."

Section 4
Patient care and treatment

Patient care and treatment

4.1 Information and involvement in decisions
Patients should be involved as much as possible in decisions about their care and given information about their condition. This survey shows that over three quarters of patients (77%) felt that they were given the right amount of information, compared with 75% in 2003. Fewer patients in 2004/2005 reported that they were not given any information at all while they were in the emergency department (7% compared with 9% in 2003). Less than 1% of all respondents complained that they were given too much information.

For those respondents who were well enough to be involved in decisions about their care, 64% felt that they were involved as much as they wanted to be, 27% felt involved to some extent and 9% reported they were not involved as much as they wanted to be in these decisions. These are similar to the results of the 2003 survey.

"I was most annoyed with my treatment when shown my x-rays. The specialist barely flashed it at me before putting it away. He left me guessing where my bone had been broken and how best to keep it comfortable!"

Patients were asked whether hospital staff gave them conflicting information. Most respondents (84%) said that this did not happen, 10% reported that it had happened to some extent, and 6% said that it had definitely happened. Respondents' views had not changed since 2003.

4.2 Staffing levels
In order for patients to receive individual attention and care, it is essential that there is an adequate number of staff available to care for them. For those respondents who needed attention, 57% were always able to get a member of staff to help them, 33% were able to get help sometimes, and 7% could not find a member of staff to help them. The remaining 3% had a member of staff with them all the time.

4.3 Privacy
Patients were asked if they were given enough privacy when discussing their condition or treatment and when they were being examined. Seventy two per cent of patients said they definitely had enough privacy when discussing their condition, and 80% that they definitely had enough privacy when being examined. This represents an improvement since the 2003 survey of 2% for both responses.

"All conversations can be heard, as there are only curtains between the cubicles. Better confidentiality would have been appreciated."

4.4 Tests

When patients were asked if they had any tests (such as x-rays, scans or blood tests) when they visited the emergency department 62% of them said "yes" in 2004/2005.

This survey showed that for patients who underwent tests, 62% were given the results in a way that they could understand, nearly a quarter were able to understand to some extent, and 9% did not have the results explained to them in a way they could understand. These results are similar to those of the 2003 survey. However there was a small increase (1%) in the percentage of patients who said that they were never told the results of the tests.

"It would have been nice to get the test results back before I left the hospital."

4.5 Pain

Experiencing pain is common for patients so it is particularly important that hospital staff manage it effectively. Most patients (69%) experienced pain while they were in the emergency department. Of these 67% reported that they were in pain all or most of the time. For respondents who requested pain medicine:

- 21% said they received it straight away
- 47% said they received it between one and 15 minutes
- 24% said it took over 15 minutes to receive it
- 9% reported that they did not receive any

The 2003 survey reported a similar pattern, although slightly more patients received pain medicine within 15 minutes (2%).

"The sister in A&E was very quick with the pain relief and fluids and staff were kind and concerned about the pain level."

Of those patients who suffered pain during their emergency department stay, 84% felt that either the hospital staff did everything they could to help control it or that they were helped to some extent (compared with 82% in 2003). That left 16% feeling that staff did not do everything that they could, but this 16% is a slight improvement since 2003.

Section 5
Hospital environment and facilities

Hospital environment and facilities

5.1 Cleanliness
Forty five per cent of patients rated the emergency department as 'very clean'. This represents a 4% decrease compared to the 2003 survey. There has been an increase in the percentage of patients rating the department as 'fairly clean' (46% compared to 43% in 2003). Two per cent of patients reported that the emergency department was 'not at all clean'. This has not changed since the 2003 survey.

The toilets in the emergency department were rated 'very clean' by just over a third of patients (39%), in comparison to 43% of patients in 2003. The number of patients rating the toilets as 'fairly clean' has increased by 2% (45% compared to 42% in 2003). Similar to the 2003 survey, 5% of patients reported the toilets were 'not at all clean'.

"Staff wore gloves but never washed between procedures."

"The toilets in the public area of A&E were a disgrace – I've seen public toilets cleaner. With MRSA this causes me great concern."

These figures, along with the direct quotes from patients, indicate the level of concern about infection rates.

5.2 Safety
The number of patients feeling threatened or bothered in emergency department appears to have decreased. In 2004/2005, 91% of patients said that they did not feel threatened or bothered by other patients. This is an increase of 2% since 2003.

Section 6
Leaving the emergency department

Leaving the emergency department

6.1 Information on medicines
Comparison of the two surveys reveals that slightly more patients in 2004/2005 reported that they were prescribed or ordered new medications (38% compared to 37% in 2003).

This survey asked patients discharged with new medications about the information they received on how to take it, the purpose of the medication, and any side effects. Most patients (85%) were given an explanation of how to take the new medications. As in the 2003 survey, almost all patients (81%) received a complete explanation of the medication's purpose. Regarding the explanation of possible side effects, fewer patients were not given any information in 2004/2005 (49% compared to 51% in 2003). Thirty six per cent of patients were given a full explanation of possible side effects, and 16% were given some information.

"I wish I'd been told what side effects to look for from my penicillin. I experienced a severe allergic reaction and did not realise early enough what was making me so ill and so kept taking the tablets and getting worse."

"I would have liked to know what my problem was and why I was given a certain medication."

6.2 Other information
Most patients (63%) were given at least some information on the danger signals to watch for following discharge from the emergency department, although 37% were not given any. There does not appear to be any difference in this since 2003.

Forty two per cent of patients were not told when they could resume normal activities. Two thirds of patients said they knew who to contact if they were worried about their condition after leaving the emergency department, which clearly leaves one third who did not know who to contact.

"Information on my injury (broken ankle) could have been more thorough. For example, when to return to work, whether to put weight on my leg, exercises to do."

"I was not informed how soon my injury was expected to improve. It did not, and now my doctor has had to arrange x-rays and further treatment. A little more information would have been more helpful."

Section 7
Overall

The majority of patients (68%) felt that the main reason they went to the emergency department was dealt with completely satisfactorily. Twenty five per cent thought it was dealt with satisfactorily to some extent, and 8% felt it was not dealt with to their satisfaction.

Eighty eight per cent of patients rated the care they received in the emergency department as good, very good or excellent. This is an increased overall percentage of patients who received what they perceived to be excellent care at 34% in 2004/2005, an improvement of 2% from 2003.

Four per cent of patients felt they were never treated with respect and dignity during their visit. The percentage of patients that felt they were treated with respect and dignity all of the time has increased (79% compared with 77% in 2003).

"Having read all the bad press about the declining NHS standards, I was most impressed by all concerned at the emergency department. Well done to everyone concerned. And yes I did tell other people how well I had been treated."

Section 8
Conclusions

The views of patients about their experience of emergency departments have improved in a number of areas since the last national survey in emergency departments, conducted in 2003. More patients report that their visit to the emergency department lasted less than four hours, and patients report shorter waits at each stage of treatment in the emergency department. There have also been improvements, although on a smaller scale, in communication by staff, information provided to patients about their care and treatment, and in patients' satisfaction with the amount of time they had to see the doctor.

Some aspects of patients' experience of care in the emergency department have remained the same, or deteriorated. Patients continue to report high levels of confidence and trust in staff, and to being treated with respect and dignity. Information provided to patients on discharge remains a concern, with a substantial proportion of patients leaving the emergency department without information about side effects of medicines, danger signals to look out for and when to resume normal activities. Patients' perception of the cleanliness of emergency departments shows a decline: fewer patients report that the emergency department was 'very clean', although the proportion of people reporting that the department was not at all clean has not increased.

Overall, patients report high and increasing levels of satisfaction with the care received in emergency departments, but there is still considerable scope to improve the information provided to patients.

Section 9

Appendix: tables of results

National average results are presented for each question, along with tables comparing respondents and those who did not respond, and comparisons with responses to relevant questions in the 2003 survey.

The results reported are results for the average NHS trust in England. The national average is calculated from adding up the overall results for each participating organisation. The responses from each trust therefore have an equal influence over the national average, regardless of differences in response rate between trusts.

The average number of patients per trust giving a specific response to each question was found, and then the number of responders in each individual trust was divided by this figure. This produces a ratio for each trust and for each question of the number of people responding in that trust by the average number of people responding in all trusts. These values are used to 'weight' the results so that all trusts have an equal influence regardless of their response rates.

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

Tables of results: Trust-based national averages for all questions

9.1 Arriving at the emergency department

Q1. How did you travel to the hospital?

	National average %	Number
In an ambulance	28	
By car	57	
By taxi	6	
On foot	3	
On public transport	5	
Other	1	
Total specific responses		54,234
Missing responses		1,105

Answered by all

Q2. How would you rate the courtesy of the emergency department receptionist?

	National average %	Number
Excellent	29	
Very good	36	
Good	23	
Fair	9	
Poor	2	
Very poor	1	
Total specific responses		49,828
I did not see a receptionist		4,496
Missing responses		1,015

Answered by all

Q3. How long did you wait before you first spoke to a nurse or doctor?

	National average %	Number
0 to 15 minutes	47	
16 to 30 minutes	29	
31 to 60 minutes	14	
More than 60 minutes	10	
Total specific responses		52,465
Don't know/can't remember		1,926
Missing responses		948

Answered by all

Q4. Overall, did you think the order in which patients were seen was fair?

	National average %	Number
Yes	90	
No	10	
Total specific responses		40,181
Can't say/don't know		13,971
Missing responses		1,187

Answered by all

Q5. From the time you first arrived at the emergency department, how long did you wait before being examined by a doctor or nurse practitioner?

	National average %	Number
I did not have to wait	16	
one to 30 minutes	38	
31 to 60 minutes	21	
More than one hour but no more than two hours	13	
More than two hours but no more than four hours	9	
More than four hours	3	
Total specific responses		52,239
Can't remember		1,309
I did not see a doctor or nurse practitioner		289
Missing responses		1,502

Answered by all

Q6. Were you told how long you would have to wait to be examined?

	National average %	Number
Yes, but the wait was shorter	16	
Yes, and I had to wait about as long as I was told	18	
Yes, but the wait was longer	10	
No, I was not told	56	
Total specific responses		40,497
Don't know/can't remember		4,441
Missing responses		481

Answered by all patients except those who did not have to wait and those who did not see a doctor or nurse practitioner

Q7. Overall, how long did your visit to the emergency department last?

	National average %	Number
Up to one hour	19	
More than one hour but no more than two hours	26	
More than two hours but no more than four hours	32	
More than four hours but no more than eight hours	18	
More than eight hours but no more than 12 hours	3	
More than 12 hours but no more than 24 hours	1	
More than 24 hours	2	
Total specific responses		51,677
Can't remember		1,824
Missing responses		1,838

Answered by all

9.2 Doctors and nurses

Q8. Did you have enough time to discuss your health or medical problem with the doctor or nurse?

	National average %	Number
Yes, definitely	66	
Yes, to some extent	27	
No	6	
Total specific responses		53,399
I did not see a doctor or a nurse		373
Missing responses		1,567

Answered by all

Q9. While you were in the emergency department, did a doctor or nurse explain your condition and treatment in a way you could understand?

	National average %	Number
Yes, completely	67	
Yes, to some extent	26	
No	7	
Total specific responses		50,979
I did not need an explanation		2,254
Missing responses		400

Answered by patients who saw a doctor or nurse

Q10. Did the doctors and nurses listen to what you had to say?

	National average %	Number
Yes, definitely	74	
Yes, to some extent	23	
No	3	
Total specific responses		53,154
Missing responses		476

Answered by patients who saw a doctor or nurse

Q11. If you had any anxieties or fears about your condition or treatment, did a doctor or nurse discuss them with you?

	National average %	Number
Yes, completely	51	
Yes, to some extent	32	
No	16	
Total specific responses		34,261
I did not have anxieties or fears		18,665
Missing responses		715

Answered by patients who saw a doctor or nurse

Q12. Did you have confidence and trust in the doctors and nurses examining and treating you?

	National average %	Number
Yes, definitely	73	
Yes, to some extent	22	
No	5	
Total specific responses		53,284
Missing responses		394

Answered by patients who saw a doctor or nurse

Q13. In your opinion, did the doctors and nurses in the emergency department know enough about your condition or treatment?

	National average %	Number
All of them knew enough	54	
Most of them knew enough	28	
Only some of them knew enough	12	
None of them knew enough	5	
Total specific responses		47,391
Don't know/can't say		5,674
Missing responses		616

Answered by patients who saw a doctor or nurse

Q14. Did doctors or nurses talk in front of you as if you weren't there?

	National average %	Number
Yes, definitely	6	
Yes, to some extent	11	
No	84	
Total specific responses		53,049
Missing responses		620

Answered by patients who saw a doctor or nurse

Section 9
Appendix: Tables of results

9.3 Patient care and treatment

Q15. While you were in the emergency department, how much information about your condition or treatment was given to you?

	National average %	Number
Not enough	15	
Right amount	77	
Too much	0	
Not given any information about treatment or condition	7	
Total specific responses		53,512
Missing responses		1,827

Answered by all

Q16. Were you given enough privacy when discussing your condition or treatment?

	National average %	Number
Yes, definitely	72	
Yes, to some extent	24	
No	4	
Total specific responses		54,099
Missing responses		1,240

Answered by all

Q17. Were you given enough privacy when being examined or treated?

	National average %	Number
Yes, definitely	80	
Yes, to some extent	17	
No	3	
Total specific responses		54,125
Missing responses		1,214

Answered by all

Q18. If you needed attention, were you able to get a member of staff to help you?

	National average %	Number
Yes, always	57	
Yes, sometimes	33	
No, I could not find a member of staff to help me	7	
A member of staff was with me all the time	3	
Total specific responses		35,760
I did not need attention		18,131
Missing responses		1,448

Answered by all

Q19. Sometimes in a hospital, a member of staff will say one thing and another will say something quite different. Did this happen to you in the emergency department?

	National average %	Number
Yes, definitely	6	
Yes, to some extent	10	
No	84	
Total specific responses		54,150
Missing responses		1,189

Answered by all

Q20. Were you involved as much as you wanted to be in decisions about your care and treatment?

	National average %	Number
Yes, definitely	64	
Yes, to some extent	27	
No	9	
Total specific responses		50,808
Not well enough to be involved in decisions about care		3,036
Missing responses		1,495

Answered by all

Q21. Did the staff treating and assessing you introduce themselves?

	National average %	Number
Yes, all of the staff introduced themselves	61	
Some of the staff introduced themselves	29	
Very few or none of the staff introduced themselves	10	
Total specific responses		50,030
Don't know/can't remember		4,194
Missing responses		1,115

Answered by all

Q22. Did you have any tests (such as x-rays, scans or blood tests) when you visited the emergency department?

	National average %	Number
Yes	62	
No	38	
Total specific responses		53,929
Missing responses		1,410

Answered by all

9.3 Patient care and treatment

Q23. Did a member of staff explain the results of the tests in a way you could understand?

	National average %	Number
Yes, definitely	62	
Yes, to some extent	24	
No	9	
I was never told the results of the tests	5	
Total specific responses		30,281
Not sure/can't remember		1,397
I was told that the results would be given at a later date		1,334
Missing responses		703

Answered by patients who had tests when they visited the emergency department

Q24. Were you in any pain while you were in the emergency department?

	National average %	Number
Yes	69	
No	31	
Total specific responses		53,859
Missing responses		1,480

Answered by all

Q25. While you were in the emergency department, how much of the time were you in pain?

	National average %	Number
All or most of the time	67	
Some of the time	27	
Occasionally	6	
Total specific responses		36,962
Missing responses		298

Answered by patients who experienced pain while they were in the emergency department

Q26. Did you request pain medicine?

	National average %	Number
Yes	30	
No	70	
Total specific responses		36,500
Missing responses		766

Answered by patients who experienced pain while they were in the emergency department

Q27. How many minutes after you requested pain medicine did it take before you got it?

	National average %	Number
0 minutes/right away	21	
One to five minutes	22	
Six to 10 minutes	15	
11 to 15 minutes	10	
16 to 30 minutes	11	
More than 30 minutes	13	
I asked for pain medicine but wasn't given any	9	
Total specific responses		10,619
Missing responses		281

Answered by patients who experienced pain and requested medicine while they were in the emergency department

Q28. Do you think the hospital staff did everything they could to help control your pain?

	National average %	Number
Yes, definitely	56	
Yes, to some extent	28	
No	16	
Total specific responses		32,249
Can't say/don't know		3,115
Missing responses		1,916

Answered by patients who experienced pain while they were in the emergency department

Section 9
Appendix: Tables of results

9.4 Hospital environment and facilities

Q29. In your opinion, how clean was the emergency department?

	National average %	Number
Very clean	45	
Fairly clean	46	
Not very clean	7	
Not at all clean	2	
Total specific responses		51,675
Can't say		2,672
Missing responses		992

Answered by all

Q30. How clean were the toilets in the emergency department?

	National average %	Number
Very clean	39	
Fairly clean	45	
Not very clean	12	
Not at all clean	5	
Total specific responses		27,516
I did not use a toilet		26,722
Missing responses		1,101

Answered by all

Q31. While you were in the emergency department, did you feel bothered or threatened by other patients?

	National average %	Number
Yes, definitely	2	
Yes, to some extent	7	
No	91	
Total specific responses		54,192
Missing responses		1,147

Answered by all

9.5 Leaving the emergency department

Q32. What happened at the end of your visit to the emergency department?

	National average %	Number
I was admitted to the same hospital as an inpatient	23	
I was transferred to a different hospital or nursing home	2	
I went home	71	
I went to stay with a friend or relative	2	
I went to stay somewhere else	2	
Total specific responses		53,854
Missing responses		1,485

Answered by all

Q33. Before you left the emergency department, were any new medications prescribed or ordered for you?

	National average %	Number
Yes	38	
No	62	
Total specific responses		39,965
Missing responses		443

Answered by patients who were not admitted to hospital at the end of their visit to the emergency department

Q34. Did a member of staff explain to you how to take the new medications?

	National average %	Number
Yes, completely	85	
Yes, to some extent	11	
No	4	
Total specific responses		14,167
I did not need an explanation		755
Missing responses		137

Answered by patients who were not admitted to hospital at the end of their visit to the emergency department and who had new medications prescribed or ordered

9.5 Leaving the emergency department

Q35. Did a member of staff explain the purpose of the medications you were to take at home in a way you could understand?

	National average %	Number
Yes, completely	81	
Yes, to some extent	14	
No	5	
Total specific responses		14,021
I did not need an explanation		889
Missing responses		156

Answered by patients who were not admitted to hospital at the end of their visit to the emergency department and who had new medications prescribed or ordered

Q36. Did a member of staff tell you about medication side effects to watch for?

	National average %	Number
Yes, completely	36	
Yes, to some extent	16	
No	49	
Total specific responses		11,211
I did not need an explanation		3,545
Missing responses		329

Answered by patients who were not admitted to hospital at the end of their visit to the emergency department and who had new medications prescribed or ordered

Information

Q37. Did a member of staff tell you when you could resume your usual activities, such as when to go back to work or drive a car?

	National average %	Number
Yes, definitely	35	
Yes, to some extent	22	
No	42	
Total specific responses		24,014
I did not need an explanation		15,312
Missing responses		1,127

Answered by patients who were not admitted to hospital at the end of their visit to the emergency department

Q38. Did a member of staff tell you about what danger signals regarding your illness or treatment to watch for after you went home?

	National average %	Number
Yes, completely	39	
Yes, to some extent	24	
No	37	
Total specific responses		23,425
I did not need an explanation		16,026
Missing responses		999

Answered by patients who were not admitted to hospital at the end of their visit to the emergency department

Q39. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left the emergency department?

	National average %	Number
Yes	66	
No	34	
Total specific responses		35,009
Don't know/can't remember		4,255
Missing responses		1,207

Answered by patients who were not admitted to hospital at the end of their visit to the emergency department

Section 9
Appendix: Tables of results

9.6 Overall

Q40. Was the main reason you went to the emergency department dealt with to your satisfaction?

	National average %	Number
Yes, completely	68	
Yes, to some extent	25	
No	8	
Total specific responses		53,907
Missing responses		1,432

Answered by all

Q41. Overall, did you feel you were treated with respect and dignity while you were in the emergency department?

	National average %	Number
Yes, all of the time	79	
Yes, sometimes	17	
No	4	
Total specific responses		54,079
Missing responses		1,260

Answered by all

Q42. Overall, how would you rate the care you received in the emergency department?

	National average %	Number
Excellent	34	
Very good	36	
Good	18	
Fair	8	
Poor	3	
Very poor	2	
Total specific responses		54,078
Missing responses		1,261

Answered by all

Section 9
Appendix: Tables of results

9.7 Demographic information

Q43. Percentage of those responding to the survey by sex

	Proportion %	Total
Male	46	
Female	54	
Total specific responses		55,332
Missing data		7

Answered by all – data taken from response but if missing taken from sample data

Q44. Percentage of those responding to the survey by age group

	Proportion %	Total
16 to 35 years	26	
36 to 50 years	24	
51 to 65 years	22	
66 years and over	28	
Total specific responses		55,339
Missing data		0

Answered by all – year of birth grouped, data taken from response but if missing taken from sample data

Q45. How old were you when you left full time education?

	Proportion %	Total
16 years or less	60	
17 or 18 years	19	
19 years or over	17	
Still in full time education	4	
Total specific responses		52,725
Missing responses		2,614

Answered by all

Q46. Overall how would you rate your health during the past four weeks?

	Proportion %	Total
Excellent	13	
Very good	22	
Good	26	
Fair	25	
Poor	11	
Very poor	3	
Total specific responses		53,962
Missing responses		1,377

Answered by all

Q47. Do you have a long standing physical or mental health problem or disability?

	Proportion %	Total
Yes	39	
No	61	
Total specific responses		53,386
Missing responses		1,953

Answered by all

Q48. Does this problem or disability affect your day-to-day activities?

	Proportion %	Total
Yes, definitely	46	
Yes, to some extent	43	
No	11	
Total specific responses		21,045
Missing responses		194

Answered by patients who have a long standing physical or mental health problem or disability

Q49. Percentage of those responding to the survey by ethnic group

	Proportion %	Total
White	93	
Asian or Asian British	3	
Black or Black British	2	
Chinese, mixed, or other ethnic group	1	
Total specific responses		54,560
Missing data		779

Answered by all – data taken from response but if missing taken from sample data

Section 9
Appendix: Tables of results

9.8 Response rates for demographic groups

Note: Adjusted response rates were calculated by dividing the total number of respondents by the total number of patients that were sent questionnaires. This does not include those to whom questionnaires could not be delivered and those who were reported to have died since the survey began.

Adjusted response rates by sex

Percentage returning completed questionnaires

Sex	Adjusted response rate %	Number of patients in group
Male	39	65,115
Female	49	61,578
Missing data		420
Overall response rate	44	127,113

Adjusted response rates by age group

Percentage returning completed questionnaires

Age Group	Adjusted response rate %	Number of patients in group
16 to 35 years	29	49,798
36 to 50 years	42	31,227
51 to 65 years	61	20,214
66 years and over	60	25,853
Missing data		21
Overall response rate	44	127,113

Adjusted response rates by sex and age group

Percentage returning completed questionnaire

Sex	Age group	Adjusted response rate (%)	Number of patients in group
Male	16 to 35 years	23	27,374
	36 to 50 years	37	16,984
	51 to 65 years	58	10,239
	66 years and over	65	10,513
	Missing data		5
Female	16 to 35 years	36	22,274
	36 to 50 years	47	14,147
	51 to 65 years	64	9,914
	66 years and over	58	15,238
	Missing data		5
Missing data			420
Overall response rate		44	127,113

Adjusted response rates by ethnic group

Percentage returning completed questionnaires

Ethnic Group	Adjusted response rate %	Number of patients in group
White	61	82,734
Asian or Asian British	44	4,199
Black or Black British	44	3,044
Chinese, mixed, or other ethnic group	53	1,389
Missing data		35,747
Overall response rate	44	127,113

Section 9
Appendix: Tables of results

9.9 Comparison of survey years

Tables of differences between comparable items in the 2003 and 2004/2005 emergency department surveys using trust-based national averages

Please note:

All values are percentages except for the total number of specific responses which are count values.

All percentages are rounded to whole numbers, which may account for apparent inconsistencies between the columns showing results for each year, and the difference column.

The percentage difference between years is calculated by subtracting the 2003 survey results from the 2004/2005 survey results. That is, responses with positive values indicate a higher proportion of patients choosing this response in the 2004/2005 survey compared with the 2003 and vice versa.

The question numbering relates to the 2004/2005 survey.

The results from the 2003 survey have been weighted to ensure all trusts have an equal influence over the national average, regardless of the trust's response rate. The method for weighting is given in the previous section (2004/2005 results). Several of the 2003 survey percentages presented here will differ slightly from those originally published in summer 2003, as the original figures were not weighted.

There are a number of questions where certain responses were included in the original 2003 emergency department survey results but have been omitted from this comparative analysis (since they are not specific responses). These are:

- Q5: 'I did not see a doctor or nurse practitioner'
- Q20: 'I was not well enough to be involved in decisions about my care'
- Q9, Q35, Q36, Q38: 'I did not need an explanation'

Section 9
Appendix: Tables of results

Q1. How did you travel to the hospital?

	Year emergency survey carried out 2003	2004/2005	% difference between years
In an ambulance	31%	28%	-2.6
By car	54%	57%	2.6
By taxi	6%	6%	-.6
On foot	3%	3%	.2
On public transport	5%	5%	.4
Other	1%	1%	.1
Number of total specific responses	58,190	54,234	

Answered by all

Q4. Overall, did you think the order in which patients were seen was fair?

	Year emergency survey carried out 2003	2004/2005	% difference between years
Yes	87%	90%	3.2
No	13%	10%	-3.2
Number of total specific responses	37,051	40,181	

Answered by all

Q5. From the time you first arrived at the emergency department, how long did you wait before being examined by a doctor or nurse practitioner?

	Year emergency survey carried out 2003	2004/2005	% difference between years
I did not have to wait	15%	16%	.8
one to 30 minutes	33%	38%	4.3
31 to 60 minutes	18%	21%	3.2
More than one hour but no more than two hours	14%	13%	-.8
More than two hours but no more than four hours	13%	9%	-3.7
More than four hours	7%	3%	-3.8
Number of total specific responses	55,606	52,239	

Answered by all

Q6. Were you told how long you would have to wait to be examined?

	Year emergency survey carried out 2003	2004/2005	% difference between years
Yes, but the wait was shorter	13%	16%	2.6
Yes, and I had to wait about as long as I was told	16%	18%	1.7
Yes, but the wait was longer	13%	10%	-2.4
No, I was not told	58%	56%	-1.9
Number of total specific responses	43,989	40,497	

Answered by all patients except those who did not have to wait and those who did not see a doctor or nurse practitioner

Q7. Overall, how long did your visit to the emergency department last?

	Year emergency survey carried out 2003	2004/2005	% difference between years
Up to one hour	17%	19%	2.2
More than one hour but no more than two hours	21%	26%	4.5
More than two hours but no more than four hours	31%	32%	1.6
More than four hours but no more than eight hours	22%	18%	-4.9
More than eight hours but no more than 12 hours	5%	3%	-2.5
More than 12 hours but no more than 24 hours	2%	1%	-1.0
More than 24 hours	2%	2%	.1
Number of total specific responses	55,053	51,677	

Answered by all

Q8. Did you have enough time to discuss your health or medical problem with the doctor or nurse?

	Year emergency survey carried out 2003	2004/2005	% difference between years
Yes, definitely	62%	66%	4.0
Yes, to some extent	30%	27%	-2.7
No	8%	6%	-1.4
Number of total specific responses	56,560	53,399	

Answered by all

Section 9
Appendix: Tables of results

Q9. While you were in the emergency department, did a doctor or nurse explain your condition and treatment in a way you could understand?

	Year emergency survey carried out 2003	2004/2005	% difference between years
Yes, completely	65%	67%	1.8
Yes, to some extent	27%	26%	-.7
No	8%	7%	-1.1
Number of total specific responses	53,959	50,979	

Answered by patients who saw a doctor or a nurse

Q10. Did the doctors and nurses listen to what you had to say?

	Year emergency survey carried out 2003	2004/2005	% difference between years
Yes, definitely	73%	74%	1.3
Yes, to some extent	23%	23%	-.7
No	4%	3%	-.7
Number of total specific responses	56,813	53,154	

Answered by patients who saw a doctor or a nurse

Q11. If you had any anxieties or fears about your condition or treatment, did a doctor or nurse discuss them with you?

	Year emergency survey carried out 2003	2004/2005	% difference between years
Yes, completely	49%	51%	2.1
Yes, to some extent	31%	32%	.8
No	19%	16%	-2.8
Number of total specific responses	34,870	34,261	

Answered by patients who saw a doctor or a nurse

Q12. Did you have confidence and trust in the doctors and nurses examining and treating you?

	Year emergency survey carried out 2003	2004/2005	% difference between years
Yes, definitely	73%	73%	-.2
Yes, to some extent	22%	22%	.5
No	5%	5%	-.3
Number of total specific responses	57,251	53,284	

Answered by patients who saw a doctor or a nurse

Q13. In your opinion, did the doctors and nurses in the emergency department know enough about your condition or treatment?

	Year emergency survey carried out 2003	2004/2005	% difference between years
All of them knew enough	55%	54%	-1.0
Most of them knew enough	27%	28%	1.4
Only some of them knew enough	12%	12%	-.3
None of them knew enough	5%	5%	-.1
Number of total specific responses	50,258	47,391	

Answered by patients who saw a doctor or a nurse

Q14. Did doctors or nurses talk in front of you as if you weren't there?

	Year emergency survey carried out 2003	2004/2005	% difference between years
Yes, definitely	6%	6%	.0
Yes, to some extent	11%	11%	.2
No	84%	84%	-.2
Number of total specific responses	56,772	53,049	

Answered by patients who saw a doctor or a nurse

Section 9
Appendix: Tables of results

Q15. While you were in the emergency department, how much information about your condition or treatment was given to you?

	Year emergency survey carried out 2003	2004/2005	% difference between years
Not enough	16%	15%	-.5
Right amount	75%	77%	2.2
Too much	0%	0%	.0
Not given any information about treatment or condition	9%	7%	-1.7
Number of total specific responses	56,847	53,512	

Answered by all

Q16. Were you given enough privacy when discussing your condition and treatment?

	Year emergency survey carried out 2003	2004/2005	% difference between years
Yes, definitely	70%	72%	1.9
Yes, to some extent	25%	24%	-.8
No	6%	4%	-1.2
Number of total specific responses	57,302	54,099	

Answered by all

Q17. Were you given enough privacy when being examined or treated?

	Year emergency survey carried out 2003	2004/2005	% difference between years
Yes, definitely	78%	80%	1.6
Yes, to some extent	19%	17%	-1.1
No	3%	3%	-.5
Number of total specific responses	57,322	54,125	

Answered by all

Q19. Sometimes in a hospital, a member of staff will say one thing and another will say something quite different. Did this happen to you in the emergency department?

	Year emergency survey carried out 2003	2004/2005	% difference between years
Yes, definitely	7%	6%	-.5
Yes, to some extent	10%	10%	.6
No	84%	84%	-.1
Number of total specific responses	57,350	54,150	

Answered by all

Q20. Were you involved as much as you wanted to be in decisions about your care and treatment?

	Year emergency survey carried out 2003	2004/2005	% difference between years
Yes, definitely	63%	64%	.7
Yes, to some extent	27%	27%	.1
No	10%	9%	-.9
Not well enough to be involved in decisions about care	0%	0%	.0
Number of total specific responses	56,883	53,844	

Answered by all

Q23. Did a member of staff explain the results of the test in a way you could understand?

	Year emergency survey carried out 2003	2004/2005	% difference between years
Yes, definitely	63%	62%	-.6
Yes, to some extent	24%	24%	.0
No	10%	9%	-.6
I was never told the results of the tests	3%	5%	1.1
Number of total specific responses	29,397	30,281	

Answered by patients who had tests when they visited the emergency department

Section 9
Appendix: Tables of results

Q24. Were you in any pain while you were in the emergency department?

	Year emergency survey carried out 2003	2004/2005	% difference between years
Yes	70%	69%	-1.3
No	30%	31%	1.3
Number of total specific responses	57,405	53,859	

Answered by all

Q25. While you were in the emergency department, how much of the time were you in pain?

	Year emergency survey carried out 2003	2004/2005	% difference between years
All or most of the time	67%	67%	-.3
Some of the time	27%	27%	.6
Occasionally	6%	6%	-.3
Number of total specific responses	40,153	36,962	

Answered by all

Q26. Did you request pain medicine?

	Year emergency survey carried out 2003	2004/2005	% difference between years
Yes	30%	30%	.3
No	70%	70%	-.3
Number of total specific responses	39,681	36,500	

Answered by patients who experienced pain whilst they were in the emergency department

Q27. How many minutes after you requested pain medicine did it take before you got it?

	Year emergency survey carried out 2003	2004/2005	% difference between years
0 minutes/right away	21%	21%	.0
one to five minutes	22%	22%	.2
six to 10 minutes	14%	15%	1.7
11 to 15 minutes	10%	10%	.0
16 to 30 minutes	10%	11%	.4
More than 30 minutes	14%	13%	-1.0
I asked for pain medicine but wasn't given any	10%	9%	-1.3
Number of total specific responses	11,649	10,619	

Answered by patients who experienced pain and requested medicine whilst they were in the emergency department

Q28. Do you think the hospital staff did everything they could to help control your pain?

	Year emergency survey carried out 2003	2004/2005	% difference between years
Yes, definitely	55%	56%	1.5
Yes, to some extent	27%	28%	.7
No	18%	16%	-2.3
Number of total specific responses	34,510	32,249	

Answered by patients who experienced pain whilst they were in the emergency department

Q29. In your opinion, how clean was the emergency department?

	Year emergency survey carried out 2003	2004/2005	% difference between years
Very clean	48%	45%	-3.8
Fairly clean	43%	46%	3.2
Not very clean	7%	7%	.6
Not at all clean	2%	2%	.0
Number of total specific responses	55,384	51,675	

Answered by all

Section 9
Appendix: Tables of results

Q30. How clean were the toilets in the emergency department?

	Year emergency survey carried out 2003	2004/2005	% difference between years
Very clean	43%	39%	-4.2
Fairly clean	42%	45%	2.4
Not very clean	10%	12%	1.7
Not at all clean	5%	5%	.1
Number of total specific responses	30,582	27,516	

Answered by all

Q31. While you were in the emergency department, did you feel bothered or threatened by other patients?

	Year emergency survey carried out 2003	2004/2005	% difference between years
Yes, definitely	3%	2%	-.6
Yes, to some extent	8%	7%	-1.1
No	89%	91%	1.6
Number of total specific responses	57,593	54,192	

Answered by all

Q32. What happened at the end of your visit to the emergency department?

	Year emergency survey carried out 2003	2004/2005	% difference between years
I was admitted to the same hospital as an inpatient	24%	23%	-.8
I was transferred to a different hospital or nursing home	2%	2%	-.1
I went home	70%	71%	.8
I went to stay with a friend or relative	3%	2%	-.3
I went to stay somewhere else	1%	2%	.5
Number of total specific responses	57,625	53,854	

Answered by all

Q33. Before you left the emergency department, were any new medications prescribed or ordered for you?

	Year emergency survey carried out 2003	2004/2005	% difference between years
Yes	37%	38%	1.2
No	63%	62%	-1.2
Number of total specific responses	41,532	39,965	

Answered by patients who were not admitted to hospital at the end of their visit to the emergency department

Q35. Did a member of staff explain the purpose of the medications you were to take at home in a way you could understand?

	Year emergency survey carried out 2003	2004/2005	% difference between years
Yes, completely	82%	81%	-.9
Yes, to some extent	13%	14%	.6
No	5%	5%	.3
Number of total specific responses	14,271	14,021	

Answered by patients who were not admitted to hospital at the end of their visit to the emergency department and were prescribed or ordered new medications

Q36. Did a member of staff tell you about medication side effects to watch for?

	Year emergency survey carried out 2003	2004/2005	% difference between years
Yes, completely	35%	36%	.3
Yes, to some extent	14%	16%	1.6
No	51%	49%	-1.9
Number of total specific responses	11,599	11,211	

Answered by patients who were not admitted to hospital at the end of their visit to the emergency department and were prescribed or ordered new medications

Section 9
Appendix: Tables of results

Q38. Did a member of staff tell you about any danger signals regarding your illness or treatment to watch for after you went home?

	Year emergency survey carried out 2003	2004/2005	% difference between years
Yes, completely	40%	39%	-.4
Yes, to some extent	23%	24%	.4
No	37%	37%	.0
Number of total specific responses	25,800	23,425	

Answered by patients who were not admitted to hospital at the end of their visit to the emergency department

Q41. Overall, did you feel you were treated with respect and dignity while you were in the emergency department?

	Year emergency survey carried out 2003	2004/2005	% difference between years
Yes, all of the time	77%	79%	1.8
Yes, sometimes	18%	17%	-.9
No	5%	4%	-.9
Number of total specific responses	57,596	54,079	

Answered by all

Q42. Overall, how would you rate the care you received in the emergency department?

	Year emergency survey carried out 2003	2004/2005	% difference between years
Excellent	31%	34%	2.3
Very good	35%	36%	1.2
Good	19%	18%	-.9
Fair	9%	8%	-1.4
Poor	3%	3%	-.6
Very poor	2%	2%	-.5
Number of total specific responses	57,710	54,078	

Answered by all

Q43. Are you male or female?

	Year emergency survey carried out 2003	2004/2005	% difference between years
Male	48%	46%	-2.0
Female	52%	54%	2.0
Number of total specific responses	59,423	55,332	

Answered by all – data taken from response but if missing taken from sample data

Q44. How old are you?

	Year emergency survey carried out 2003	2004/2005	% difference between years
16 to 35 years	28%	26%	-1.8
36 to 50 years	23%	24%	.4
51 to 65 years	22%	22%	.2
66 years and over	27%	28%	1.3
Number of total specific responses	59,438	55,339	

Answered by all – data taken from response but if missing taken from sample data

Q45. How old were you when you left full time education?

	Year emergency survey carried out 2003	2004/2005	% difference between years
16 years or less	60%	60%	.2
17 or 18 years	20%	19%	-.5
19 years or over	16%	17%	.9
Still in full time education	4%	4%	-.5
Number of total specific responses	56,629	52,725	

Answered by all

Q46. Overall, how would you rate your health during the past 4 weeks?

	Year emergency survey carried out 2003	2004/2005	% difference between years
Excellent	13%	13%	.3
Very good	22%	22%	.5
Good	26%	26%	-.2
Fair	25%	25%	-.4
Poor	11%	11%	-.1
Very poor	3%	3%	.0
Number of total specific responses	57,807	53,962	

Answered by all

Q49. To which of these ethnic groups would you say you belong?

	Year emergency survey carried out 2003	2004/2005	% difference between years
White	93%	93%	-.3
Asian or Asian British	3%	3%	.3
Black or Black British	2%	2%	.1
Chinese, Mixed, or other ethnic group	1%	1%	-.1
Number of total specific responses	57,624	54,560	

Answered by all – data taken from response but if missing taken from sample data

References

1. *Accident and emergency (A&E) patient survey 2003.* Commission for Health Improvement. London. http://www.healthcarecommission.org.uk/PatientSurveyAandE2003

2. *The NHS Plan: a plan for investment, a plan for reform.* Department of Health 2000 http://www.dh.gov.uk/assetRoot/04/05/57/83/04055783.pdf

Further information

Full details of the survey methodology can be found at: http://www.nhssurveys.org/docs/Emergency_Guidance2005_V3.pdf

More information on the NHS Patient Survey Programme is available on the NHS Surveys Advice Centre website: http://www.nhssurveys.org/

The questionnaire and scores given to each response can be found at: http://www.healthcarecommission.org.uk/PatientSurveyAandE2004

More information on the 2004/2005 NHS performance ratings is available on the Healthcare Commission website: http://www.healthcarecommission.org.uk/

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