Local Health Services Questionnaire

What is the survey about?

This survey is about your experience of the services provided by the National Health Service in your area.

Who should complete the questionnaire?

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

Completing the questionnaire

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

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

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

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

Questions or help?

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

Your participation in this survey is voluntary.

If you choose not to take part in this survey it will not affect the care you receive from the NHS in any way. If you do not wish to take part, or you do not want to answer some of the questions, you do not have to give us a reason.

Your answers will be treated **in confidence.**

A. MAKING AN APPOINTMENT

Please answer these questions thinking about any health care EITHER for yourself OR for a child in your care

A1. Have you **made an appointment** with a doctor from your GP surgery/ health centre in the last 12 months?

1 ☐ Yes ➔ **Go to A2**

2 ☐ No ➔ **Go to B1**

Thinking about your LAST appointment or home visit …

A2. The **last** time you saw a doctor from your GP surgery did you have to wait for an appointment?

1 ☐ No, I was seen without an appointment ➔ **Go to B1**

2 ☐ I was seen on the same working day ➔ **Go to B1**

3 ☐ I had to wait 1 or 2 working days ➔ **Go to A3**

4 ☐ I had to wait more than 2 working days ➔ **Go to A3**

5 ☐ It was a pre-planned appointment or visit ➔ **Go to B1**

6 ☐ Can't remember ➔ **Go to B1**

A3. How do you feel about the length of time you had to wait for an appointment with a doctor?

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

2 ☐ I should have been seen **a bit sooner**

3 ☐ I should have been seen **a lot sooner**

A4. What was the main reason you had to wait? (**Tick ONE only**)

1 ☐ I wanted to see **my own choice** of doctor

2 ☐ I could not get an earlier appointment with **any** doctor at my GP surgery

3 ☐ It was **not convenient for me** to have an appointment at any earlier time

4 ☐ Another reason

B. VISITING THE GP SURGERY

B1. Have you **visited** your GP surgery/ health centre in the last 12 months?

1 ☐ Yes ➔ **Go to B2**

2 ☐ No ➔ **Go to C1**

Thinking about your LAST visit to the GP surgery/ health centre…

B2. When you arrived, how would you rate the courtesy of the receptionist?

1 ☐ Excellent

2 ☐ Very good

3 ☐ Good

4 ☐ Fair

5 ☐ Poor

6 ☐ Very poor

B3. In the **reception** area, could other patients overhear what you talked about with the receptionist?

1 ☐ Yes, and I was **not happy** about it

2 ☐ Yes, but I did not mind

3 ☐ No, others could not overhear

4 ☐ Don't know/ Can't say

B4. How long **after your appointment time** did you have to wait to be seen?

1 ☐ I did not have an appointment ➔ **Go to B5**
2 ☐ Seen on time or early ➔ **Go to C1**
3 ☐ Waited up to 15 minutes ➔ **Go to B5**
4 ☐ Waited 16-30 minutes ➔ **Go to B5**
5 ☐ Waited 31 minutes or longer ➔ **Go to B5**
6 ☐ Can't remember ➔ **Go to B5**

B5. Did someone tell you how long you would have to wait?

1 ☐ Yes
2 ☐ No, but I would have liked to have been told
3 ☐ No, but I did not mind
4 ☐ Not sure/ Can't remember

C. SEEING A DOCTOR

C1. Have you seen **a doctor** from your GP surgery/ health centre in the last 12 months?

1 ☐ Yes ➔ **Go to C2**
2 ☐ No ➔ **Go to D1**

Thinking about the <u>last time</u> you saw a doctor from your GP surgery…

C2. Did the doctor **listen carefully** to what you had to say?

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

C3. Were you given **enough time** to discuss your health or medical problem with the doctor?

1 ☐ Yes, definitely
2 ☐ Yes, to some extent
3 ☐ No
4 ☐ I did not need to discuss anything

C4. Were you involved as much as you wanted to be in decisions about your care and treatment?

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

C5. Did the doctor explain the reasons for any treatment or action in a way that you could understand?

1 ☐ Yes, completely
2 ☐ Yes, to some extent
3 ☐ No
4 ☐ I did not need an explanation
5 ☐ No treatment or action was needed

C6. Did you have **confidence and trust** in the doctor?

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

C7. Did the doctor treat you with **respect and dignity**?

1 ☐ Yes, all of the time
2 ☐ Yes, some of the time
3 ☐ No

C8. If you had **questions** to ask the doctor, did you get answers that you could understand?

1 ☐ Yes, definitely
2 ☐ Yes, to some extent
3 ☐ No
4 ☐ I did not need to ask any questions
5 ☐ I did not have an opportunity to ask questions

D. MEDICINES (e.g. tablets, ointment, oral contraceptives)

D1. In the last 12 months, have you had any **new** medicine(s) (including tablets, suppositories, injections) prescribed for you by a doctor or nurse practitioner from your GP surgery/health centre?

1 ☐ Yes ➔ **Go to D2**
2 ☐ No ➔ **Go to D6**
3 ☐ Can't remember ➔ **Go to D6**

Thinking about the LAST time you had a new medicine prescribed for you by someone from your surgery…

D2. Were you involved as much as you wanted to be in decisions about the best medicine for you?

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

D3. Were you given enough information about the **purpose** of the medicine?

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

Still thinking about the last time you had a new medicine prescribed for you…

D4. 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

D5. Were you given enough information about **how to use** the medicine (e.g. when to take it, how long you should take it for, whether it should be taken with food)?

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

D6. Have you been taking any prescribed medicine(s) for 12 months or longer?

1 ☐ Yes ➔ **Go to D7**
2 ☐ No ➔ **Go to E1**

D7. In the last 12 months, have you seen anyone at your GP surgery to check how you are getting on with this medicine (i.e. have your medicines been reviewed)?

1 ☐ Yes
2 ☐ No
3 ☐ Don't know/ Not sure

E. TESTS

E1. In the last 12 months, have you had any tests (e.g. blood tests, swabs, smear tests) carried out by **anyone** from your health centre?

1 ☐ Yes ➔ **Go to E2**
2 ☐ No ➔ **Go to F1**
3 ☐ Can't remember ➔ **Go to F1**

Thinking about your most recent test(s)….

E2. Was the **purpose** of the test(s) explained in a way you could understand?

1 ☐ Yes, completely
2 ☐ Yes, to some extent
3 ☐ No
4 ☐ Not sure/ Can't remember

E3. Did someone explain the results of the tests in a way you could understand?

1 ☐ Yes, definitely

2 ☐ Yes, to some extent

3 ☐ No

4 ☐ I am still waiting for the results

5 ☐ Not sure/ Can't remember

F. REFERRALS

F1. In the last 12 months, has anyone at your surgery referred you to a specialist (e.g. a hospital consultant)?

1 ☐ Yes ➔ **Go to F2**

2 ☐ No ➔ **Go to G1**

F2. Were you given a choice about **where** you were referred (i.e. **which hospital**)?

1 ☐ Yes

2 ☐ No, but I would have liked a choice

3 ☐ No, but I did not mind

4 ☐ Don't know/ Can't remember

F3. When you first saw the person you were referred to, did he/she seem to have all the necessary information about you and your condition or treatment?

1 ☐ Yes, completely

2 ☐ Yes, to some extent

3 ☐ No

4 ☐ I have not been yet

5 ☐ Don't know/ Can't remember

G. SEEING ANOTHER PROFESSIONAL FROM A HEALTH CENTRE

G1. Have you seen anyone else from a health centre **other than a doctor** in the last 12 months?

1 ☐ Yes ➔ **Go to G2**

2 ☐ No ➔ **Go to H1**

G2. The **last time** you saw someone other than a doctor from a GP surgery or health centre, who did you see? (**Tick ONE only**)

1 ☐ A practice nurse or nurse practitioner

2 ☐ A midwife

3 ☐ A district nurse

4 ☐ A health visitor

5 ☐ Someone else

6 ☐ I was not sure who I saw

Still thinking about the <u>last time</u> you saw someone other than a doctor from your GP surgery…

G3. Were you involved as much as you wanted to be in decisions about your care and treatment?

1 ☐ Yes, definitely

2 ☐ Yes, to some extent

3 ☐ No

4 ☐ No decisions had to be made

G4. Did that person explain the reasons for any treatment or action in a way that you could understand?

1 ☐ Yes, completely

2 ☐ Yes, to some extent

3 ☐ No

4 ☐ I did not need an explanation

5 ☐ No treatment or action was needed

G5. Did you have **confidence and trust** in that person?

1 ☐ Yes, definitely

2 ☐ Yes, to some extent

3 ☐ No

G6. Did that person treat you with **respect and dignity**?

1 ☐ Yes, all of the time

2 ☐ Yes, some of the time

3 ☐ No

H. OVERALL ABOUT YOUR GP SURGERY/ HEALTH CENTRE

H1. In your opinion, how clean is the surgery/health centre?

1 ☐ Very clean

2 ☐ Fairly clean

3 ☐ Not very clean

4 ☐ Not at all clean

5 ☐ Can't say

H2. In the last 12 months, have you ever been put off going to your GP surgery/health centre because the opening times are inconvenient for you?

1 ☐ Yes, often

2 ☐ Yes, sometimes

3 ☐ No

J. DENTAL CARE

J1. Are you currently registered with a dentist as **an NHS patient**?

1 ☐ Yes ➔ **Go to J3**

2 ☐ No, but I am registered with a dentist as a **non-NHS** patient ➔ **Go to J2**

3 ☐ No, I am **not registered** with any dentist at all ➔ **Go to J2**

4 ☐ Don't know ➔ **Go to J2**

J2. Would you **like to** be registered with a dentist as an NHS patient?

1 ☐ Yes

2 ☐ No

J3. In the last 12 months, have you visited a dentist **as an NHS patient**?

1 ☐ Yes ➔ **Go to J4**

2 ☐ No ➔ **Go to K1**

3 ☐ Not sure/ Can't remember ➔ **Go to K1**

Thinking about your last visit as an NHS dental patient…

J4. Were you involved as much as you wanted to be in decisions about your dental care and treatment?

1 ☐ Yes, definitely

2 ☐ Yes, to some extent

3 ☐ No

J5. Did the dentist explain the reasons for any treatment or action in a way that you could understand?

1 ☐ Yes, completely

2 ☐ Yes, to some extent

3 ☐ No

4 ☐ I did not need an explanation

5 ☐ No treatment or action was needed

J6. Did dental staff do everything they could to help control any pain you experienced?

1 ☐ Yes, definitely

2 ☐ Yes, to some extent

3 ☐ No

4 ☐ Can't say/ Don't know

5 ☐ I did not experience any pain

J7. Did you have **confidence and trust** in the dentist?

1 ☐ Yes, completely

2 ☐ Yes, to some extent

3 ☐ No

K. HEALTH PROMOTION

K1. Have you ever smoked a cigarette, a cigar or a pipe?

1 ☐ Yes ➔ **Go to K2**

2 ☐ No ➔ **Go to K4**

K2. Do you smoke cigarettes at all nowadays?

1 ☐ Yes ➔ **Go to K3**

2 ☐ No ➔ **Go to K4**

K3. In the last 12 months, have you been given advice or help from your GP surgery/health centre on **giving up smoking**?

1 ☐ Yes, definitely

2 ☐ Yes, to some extent

3 ☐ No, but I would have liked help/advice

4 ☐ No, but I did not want any help/advice

K4. In the last 12 months have you had your **blood pressure** taken by anyone from your GP surgery/ health centre?

1 ☐ Yes

2 ☐ No

3 ☐ Not sure/ Can't remember

K5. In the last 12 months, have you been offered a **flu jab** (influenza vaccination)?

1 ☐ Yes, and I have had a flu jab in the last 12 months

2 ☐ I have been offered it but I have not had a flu jab in the last 12 months

3 ☐ No, I have not been offered a flu jab in the last 12 months

4 ☐ I do not think I need a flu jab

5 ☐ Not sure/ Can't remember

L. ABOUT YOU

L1. Are you male or female?

1 ☐ Male

2 ☐ Female

L2. What was your **year** of birth?

(Please write in) e.g.

1	9	3	4

L3. 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

L4. 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

L5. 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)**

M. OTHER COMMENTS

Is there anything particularly good about your local health care?

Is there anything that could be improved?

Any other comments?

THANK YOU VERY MUCH FOR YOUR HELP

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

Please post this questionnaire back in the FREEPOST envelope provided.

No stamp is needed.

Local Health Services Questionnaire

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Your answers will be treated **in confidence.**

A. MAKING AN APPOINTMENT

Please answer these questions thinking about any health care EITHER for yourself OR for a child in your care

A1. Have you **made an appointment** with a doctor from your GP surgery/ health centre in the last 12 months?

1 ☐ Yes ➔ **Go to A2**

2 ☐ No ➔ **Go to B1**

Thinking about your LAST appointment or home visit …

A2. The **last** time you saw a doctor from your GP surgery did you have to wait for an appointment?

100 1 ☐ No, I was seen without an appointment ➔ **Go to B1**

100 2 ☐ I was seen on the same working day ➔ **Go to B1**

50 3 ☐ I had to wait 1 or 2 working days ➔ **Go to A3**

0 4 ☐ I had to wait more than 2 working days ➔ **Go to A3**

\- 5 ☐ It was a pre-planned appointment or visit ➔ **Go to B1**

\- 6 ☐ Can't remember ➔ **Go to B1**

A3. How do you feel about the length of time you had to wait for an appointment with a doctor?

100 1 ☐ I was seen as soon as I thought was necessary

50 2 ☐ I should have been seen **a bit sooner**

0 3 ☐ I should have been seen **a lot sooner**

A4. What was the main reason you had to wait? (**Tick ONE only**)

1 ☐ I wanted to see **my own choice** of doctor

2 ☐ I could not get an earlier appointment with **any** doctor at my GP surgery

3 ☐ It was **not convenient for me** to have an appointment at any earlier time

4 ☐ Another reason

B. VISITING THE GP SURGERY

B1. Have you **visited** your GP surgery/ health centre in the last 12 months?

1 ☐ Yes ➔ **Go to B2**

2 ☐ No ➔ **Go to C1**

Thinking about your LAST visit to the GP surgery/ health centre…

B2. When you arrived, how would you rate the courtesy of the receptionist?

100 1 ☐ Excellent

80 2 ☐ Very good

60 3 ☐ Good

40 4 ☐ Fair

20 5 ☐ Poor

0 6 ☐ Very poor

B3. In the **reception** area, could other patients overhear what you talked about with the receptionist?

0 1 ☐ Yes, and I was **not happy** about it

\- 2 ☐ Yes, but I did not mind

100 3 ☐ No, others could not overhear

\- 4 ☐ Don't know/ Can't say

B4. How long **after your appointment time** did you have to wait to be seen?

- \- 1 ☐ I did not have an appointment ➔ Go to B5
- 100 2 ☐ Seen on time or early ➔ Go to C1
- 67 3 ☐ Waited up to 15 minutes ➔ Go to B5
- 33 4 ☐ Waited 16-30 minutes ➔ Go to B5
- 0 5 ☐ Waited 31 minutes or longer ➔ Go to B5
- \- 6 ☐ Can't remember ➔ Go to B5

B5. Did someone tell you how long you would have to wait?

- 100 1 ☐ Yes
- 0 2 ☐ No, but I would have liked to have been told
- \- 3 ☐ No, but I did not mind
- \- 4 ☐ Not sure/ Can't remember

C. SEEING A DOCTOR

C1. Have you seen **a doctor** from your GP surgery/ health centre in the last 12 months?

- 1 ☐ Yes ➔ **Go to C2**
- 2 ☐ No ➔ **Go to D1**

Thinking about the <u>last time</u> you saw a doctor from your GP surgery…

C2. Did the doctor **listen carefully** to what you had to say?

- 100 1 ☐ Yes, definitely
- 50 2 ☐ Yes, to some extent
- 0 3 ☐ No

C3. Were you given **enough time** to discuss your health or medical problem with the doctor?

- 100 1 ☐ Yes, definitely
- 50 2 ☐ Yes, to some extent
- 0 3 ☐ No
- \- 4 ☐ I did not need to discuss anything

C4. Were you involved as much as you wanted to be in decisions about your care and treatment?

- 100 1 ☐ Yes, definitely
- 50 2 ☐ Yes, to some extent
- 0 3 ☐ No

C5. Did the doctor explain the reasons for any treatment or action in a way that you could understand?

- 100 1 ☐ Yes, definitely
- 50 2 ☐ Yes, to some extent
- 0 3 ☐ No
- \- 4 ☐ I did not need an explanation
- \- 5 ☐ No treatment or action was needed

C6. Did you have **confidence and trust** in the doctor?

- 100 1 ☐ Yes, definitely
- 50 2 ☐ Yes, to some extent
- 0 3 ☐ No

C7. Did the doctor treat you with **respect and dignity**?

- 100 1 ☐ Yes, all of the time
- 50 2 ☐ Yes, some of the time
- 0 3 ☐ No

C8. If you had **questions** to ask the doctor, did you get answers that you could understand?

- 100 1 ☐ Yes, definitely
- 50 2 ☐ Yes, to some extent
- 0 3 ☐ No
- \- 4 ☐ I did not need to ask any questions
- \- 5 ☐ I did not have an opportunity to ask questions

D. MEDICINES (e.g. tablets, ointment, oral contraceptives)

D1. In the last 12 months, have you had any **new** medicine(s) (including tablets, suppositories, injections) prescribed for you by a doctor or nurse practitioner from your GP surgery/health centre?

- 1 ☐ Yes ➔ **Go to D2**
- 2 ☐ No ➔ **Go to D6**
- 3 ☐ Can't remember ➔ **Go to D6**

Thinking about the LAST time you had a new medicine prescribed for you by someone from your surgery…

D2. Were you involved as much as you wanted to be in decisions about the best medicine for you?

- 100 1 ☐ Yes, definitely
- 50 2 ☐ Yes, to some extent
- 0 3 ☐ No

D3. Were you given enough information about the **purpose** of the medicine?

- 100 1 ☐ **Yes**, enough information
- 50 2 ☐ **Some**, but I would have liked more
- 0 3 ☐ I got **no information**, but I wanted some
- \- 4 ☐ **I did not want/need** any information
- \- 5 ☐ Don't know/ Can't say

Still thinking about the <u>last time</u> you had a new medicine prescribed for you…

D4. Were you given enough information about any **side-effects** the medicine might have?

- 100 1 ☐ **Yes**, enough information
- 50 2 ☐ **Some**, but I would have liked more
- 0 3 ☐ I got **no information**, but I wanted some
- \- 4 ☐ **I did not want/need** any information
- \- 5 ☐ Don't know/ Can't say

D5. Were you given enough information about **how to use** the medicine (e.g. when to take it, how long you should take it for, whether it should be taken with food)?

- 100 1 ☐ **Yes**, enough information
- 50 2 ☐ **Some**, but I would have liked more
- 0 3 ☐ I got **no information**, but I wanted some
- \- 4 ☐ **I did not want/need** any information
- \- 5 ☐ Don't know/ Can't say

D6. Have you been taking any prescribed medicine(s) for 12 months or longer?

- 1 ☐ Yes ➔ **Go to D7**
- 2 ☐ No ➔ **Go to E1**

D7. In the last 12 months, have you seen anyone at your GP surgery to check how you are getting on with this medicine (i.e. have your medicines been reviewed)?

- 100 1 ☐ Yes
- 0 2 ☐ No
- \- 3 ☐ Don't know/ Not sure

E. TESTS

E1. In the last 12 months, have you had any tests (e.g. blood tests, swabs, smear tests) carried out by **anyone** from your health centre?

- 1 ☐ Yes ➔ **Go to E2**
- 2 ☐ No ➔ **Go to F1**
- 3 ☐ Can't remember ➔ **Go to F1**

Thinking about your most recent test(s)….

E2. Was the **purpose** of the test(s) explained in a way you could understand?

- 100 1 ☐ Yes, completely
- 50 2 ☐ Yes, to some extent
- 0 3 ☐ No
- \- 4 ☐ Not sure/ Can't remember

E3. Did someone explain the results of the tests in a way you could understand?

100 ₁ ☐ Yes, definitely

50 ₂ ☐ Yes, to some extent

0 ₃ ☐ No

- ₄ ☐ I am still waiting for the results

- ₅ ☐ Not sure/ Can't remember

F. REFERRALS

F1. In the last 12 months, has anyone at your surgery referred you to a specialist (e.g. a hospital consultant)?

1 ☐ Yes **➔ Go to F2**

2 ☐ No **➔ Go to G1**

F2. Were you given a choice about **where** you were referred (i.e. **which hospital**)?

100 1 ☐ Yes

0 2 ☐ No, but I would have liked a choice

- 3 ☐ No, but I did not mind

- 4 ☐ Don't know/ Can't remember

F3. When you first saw the person you were referred to, did he/she seem to have all the necessary information about you and your condition or treatment?

100 1 ☐ Yes, completely

50 2 ☐ Yes, to some extent

0 3 ☐ No

- 4 ☐ I have not been yet

- 5 ☐ Don't know/ Can't remember

G. SEEING ANOTHER PROFESSIONAL FROM A HEALTH CENTRE

G1. Have you seen anyone else from a health centre **other than a doctor** in the last 12 months?

1 ☐ Yes **➔ Go to G2**

2 ☐ No **➔ Go to H1**

G2. The **last time** you saw someone other than a doctor from a GP surgery or health centre, who did you see? (**Tick ONE only**)

1 ☐ A practice nurse or nurse practitioner

2 ☐ A midwife

3 ☐ A district nurse

4 ☐ A health visitor

5 ☐ Someone else

6 ☐ I was not sure who I saw

Still thinking about the <u>last time</u> you saw someone other than a doctor from your GP surgery…

G3. Were you involved as much as you wanted to be in decisions about your care and treatment?

100 1 ☐ Yes, definitely

50 2 ☐ Yes, to some extent

0 3 ☐ No

- 4 ☐ No decisions had to be made

G4. Did that person explain the reasons for any treatment or action in a way that you could understand?

100 1 ☐ Yes, completely

50 2 ☐ Yes, to some extent

0 3 ☐ No

- 4 ☐ I did not need an explanation

- 5 ☐ No treatment or action was needed

G5. Did you have **confidence and trust** in that person?

100 1 ☐ Yes, definitely

50 2 ☐ Yes, to some extent

0 3 ☐ No

G6. Did that person treat you with **respect and dignity**?

100 1 ☐ Yes, all of the time

50 2 ☐ Yes, some of the time

0 3 ☐ No

H. OVERALL ABOUT YOUR GP SURGERY/ HEALTH CENTRE

H1. In your opinion, how clean is the surgery/health centre?

100 1 ☐ Very clean

67 2 ☐ Fairly clean

33 3 ☐ Not very clean

0 4 ☐ Not at all clean

- 5 ☐ Can't say

H2. In the last 12 months, have you ever been put off going to your GP surgery/health centre because the opening times are inconvenient for you?

0 1 ☐ Yes, often

50 2 ☐ Yes, sometimes

100 3 ☐ No

J. DENTAL CARE

J1. Are you currently registered with a dentist as **an NHS patient**?

If the response to J2 is option 1 ("Yes"), a score of 100 is assigned to option 1 and options 2 and 3 score 0. If the response to J2 is option 2 or missing, a score of 100 is assigned to option 1 (J1) and options 2, 3 and 4 are not scored.

100 1 ☐ Yes ➔ **Go to J3**

0 2 ☐ No, but I am registered with a dentist as a **non-NHS** patient ➔ **Go to J2**

0 3 ☐ No, I am **not registered** with any dentist at all ➔ **Go to J2**

- 4 ☐ Don't know ➔ **Go to J2**

J2. Would you **like to** be registered with a dentist as an NHS patient?

1 ☐ Yes

2 ☐ No

J3. In the last 12 months, have you visited a dentist **as an NHS patient**?

1 ☐ Yes ➔ **Go to J4**

2 ☐ No ➔ **Go to K1**

3 ☐ Not sure/ Can't remember ➔ **Go to K1**

Thinking about your last visit as an NHS dental patient…

J4. Were you involved as much as you wanted to be in decisions about your dental care and treatment?

100 1 ☐ Yes, definitely

50 2 ☐ Yes, to some extent

0 3 ☐ No

J5. Did the dentist explain the reasons for any treatment or action in a way that you could understand?

100 1 ☐ Yes, completely

50 2 ☐ Yes, to some extent

0 3 ☐ No

- 4 ☐ I did not need an explanation

- 5 ☐ No treatment or action was needed

J6. Did dental staff do everything they could to help control any pain you experienced?

100 1 ☐ Yes, definitely

50 2 ☐ Yes, to some extent

0 3 ☐ No

- 4 ☐ Can't say/ Don't know

- 5 ☐ I did not experience any pain

J7. Did you have **confidence and trust** in the dentist?

100 ₁ ☐ Yes, completely

50 ₂ ☐ Yes, to some extent

0 ₃ ☐ No

K. HEALTH PROMOTION

K1. Have you ever smoked a cigarette, a cigar or a pipe?

1 ☐ Yes ➔ **Go to K2**

2 ☐ No ➔ **Go to K4**

K2. Do you smoke cigarettes at all nowadays?

1 ☐ Yes ➔ **Go to K3**

2 ☐ No ➔ **Go to K4**

K3. In the last 12 months, have you been given advice or help from your GP surgery/health centre on **giving up smoking**?

100 1 ☐ Yes, definitely

50 2 ☐ Yes, to some extent

0 3 ☐ No, but I would have liked help/advice

- 4 ☐ No, but I did not want any help/advice

K4. In the last 12 months have you had your **blood pressure** taken by anyone from your GP surgery/ health centre?

100 1 ☐ Yes

0 2 ☐ No

- 3 ☐ Not sure/ Can't remember

K5. In the last 12 months, have you been offered a **flu jab** (influenza vaccination)?

100 1 ☐ Yes, and I have had a flu jab in the last 12 months

50 2 ☐ I have been offered it but I have not had a flu jab in the last 12 months

0 3 ☐ No, I have not been offered a flu jab in the last 12 months

- 4 ☐ I do not think I need a flu jab

- 5 ☐ Not sure/ Can't remember

L. ABOUT YOU

L1. Are you male or female?

1 ☐ Male

2 ☐ Female

L2. What was your **year** of birth?

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

L3. 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

L4. 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

L5. 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)**

M. OTHER COMMENTS

Is there anything particularly good about your local health care?

Is there anything that could be improved?

Any other comments?

THANK YOU VERY MUCH FOR YOUR HELP

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

Please post this questionnaire back in the FREEPOST envelope provided.

No stamp is needed.

Non survey variable definitions: PCT 2004 survey data

1. trustcod Trust code (please see table 1 or trust list_pct (04).xls for the name of trusts)
2. trustnum: Trust number
3. sample_r: Sample Reference Number
4. 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
5. age: Patient's age taken from the trusts' administrative systems, where available it may be preferable to use self reported age instead (question I2)
6. gender: Gender, taken from the trusts' administrative systems, where available it may be preferable to use self reported gender instead (question I1)
   - Male=1
   - Female=2

7. comp_age computed age based on patient provided information (question I2)

Table 1. Name and number of trusts

Trust code	Trust name
RGT	Addenbrooke's NHS Trust
REM	Aintree Hospitals NHS Trust
RCF	Airedale NHS Trust
RTK	Ashford and St Peter's Hospitals NHS Trust
RF4	Barking, Havering and Redbridge Hospitals NHS Trust
RVL	Barnet and Chase Farm Hospitals NHS Trust
RFF	Barnsley District General Hospital NHS Trust
RNJ	Barts and The London NHS Trust
RDD	Basildon and Thurrock University Hospitals NHS Trust
RC1	Bedford Hospitals NHS Trust
RR1	Birmingham Heartlands and Solihull (Teaching) NHS Trust
RLU	Birmingham Women's Health Care NHS Trust

RXL Blackpool, Fylde and Wyre Hospitals NHS Trust
RMC Bolton Hospitals NHS Trust
RAE Bradford Teaching Hospitals NHS Trust
RXH Brighton and Sussex University Hospitals NHS Trust
RG3 Bromley Hospitals NHS Trust
RXQ Buckinghamshire Hospitals NHS Trust
RJF Burton Hospitals NHS Trust
RWY Calderdale and Huddersfield NHS Trust
RW3 Central Manchester and Manchester Children's University Hospitals NHS Trust
RQM Chelsea and Westminster Healthcare NHS Trust
RFS Chesterfield and North Derbyshire Royal Hospital NHS Trust
RBV Christie Hospital NHS Trust
RLN City Hospitals Sunderland NHS Trust
REN Clatterbridge Centre For Oncology NHS Trust
RJR Countess Of Chester Hospital NHS Trust
RXP County Durham and Darlington Acute Hospitals NHS Trust *
RN7 Dartford and Gravesham NHS Trust
RP5 Doncaster and Bassetlaw Hospitals NHS Trust
RNA Dudley Group Of Hospitals NHS Trust
RC3 Ealing Hospital NHS Trust
RWH East and North Hertfordshire NHS Trust
RJN East Cheshire NHS Trust
RVV East Kent Hospitals NHS Trust
RXR East Lancashire Hospitals NHS Trust
RA4 East Somerset NHS Trust
RXC East Sussex Hospitals NHS Trust
RVR **Epsom and St Helier University Hospitals NHS Trust**
RDE Essex Rivers Healthcare NHS Trust
RDU Frimley Park Hospital NHS Trust
RR7 Gateshead Health NHS Trust
RLT George Eliot Hospital NHS Trust
RTE Gloucestershire Hospitals NHS Trust
RJH Good Hope Hospital NHS Trust
RJ1 Guy's and St Thomas' NHS Trust
RQN Hammersmith Hospitals NHS Trust
RCD Harrogate Health Care NHS Trust
RD7 Heatherwood and Wexham Park Hospitals NHS Trust
RLQ Hereford Hospitals NHS Trust
RQQ Hinchingbrooke Health Care NHS Trust
RQX Homerton University Hospital NHS Trust
RWA Hull and East Yorkshire Hospitals NHS Trust
RGQ Ipswich Hospital NHS Trust
RR2 Isle Of Wight Healthcare NHS Trust
RGP James Paget Healthcare NHS Trust
RNQ Kettering General Hospital NHS Trust
RJZ King's College Hospital NHS Trust
RCX Kings Lynn and Wisbech Hospitals NHS Trust
RAX Kingston Hospital NHS Trust
RXN Lancashire Teaching Hospitals NHS Trust
RR8 Leeds Teaching Hospitals NHS Trust
REP Liverpool Womens Hospital NHS Trust
RC9 Luton and Dunstable Hospital NHS Trust

RWF Maidstone and Tunbridge Wells NHS Trust
RJ6 Mayday Healthcare NHS Trust
RPA Medway NHS Trust
RQ8 Mid Essex Hospital Services NHS Trust
RJD Mid Staffordshire General Hospitals NHS Trust
RXF Mid Yorkshire Hospitals NHS Trust
RD8 Milton Keynes General Hospital NHS Trust
RP6 Moorfields Eye Hospital NHS Trust
RTX Morecambe Bay Hospitals NHS Trust
RNH Newham Healthcare NHS Trust
RM1 Norfolk and Norwich University Hospital NHS Trust
RVJ North Bristol NHS Trust
RWW North Cheshire Hospitals NHS Trust
RNL North Cumbria Acute Hospitals NHS Trust
RN5 North Hampshire Hospitals NHS Trust
RAP North Middlesex University Hospital NHS Trust
RVW North Tees and Hartlepool NHS Trust
RV8 North West London Hospitals NHS Trust
RNS Northampton General Hospital NHS Trust
RBZ Northern Devon Healthcare NHS Trust
RJL Northern Lincolnshire and Goole Hospitals NHS Trust
RTF Northumbria Health Care NHS Trust
RCS Nottingham City Hospital NHS Trust
RBF Nuffield Orthopaedic NHS Trust
RTH Oxford Radcliffe Hospital NHS Trust
RGM Papworth Hospital NHS Trust
RW6 Pennine Acute Hospitals NHS Trust
RGN Peterborough Hospitals NHS Trust
RK9 Plymouth Hospitals NHS Trust
RD3 Poole Hospitals NHS Trust
RHU Portsmouth Hospitals NHS Trust
RG2 Queen Elizabeth Hospital NHS Trust
RGZ Queen Mary's Sidcup NHS Trust
RFK Queen's Medical Centre, Nottingham University Hospital NHS Trust
RL1 Robert Jones and Agnes Hunt Orthopaedic and District Hospital NHS Trust
RFR Rotherham General Hospitals NHS Trust
RHW Royal Berkshire and Battle Hospitals NHS Trust
RDZ Royal Bournemouth and Christchurch Hospitals NHS Trust
RT3 Royal Brompton and Harefield NHS Trust
REF Royal Cornwall Hospitals NHS Trust
RH8 Royal Devon and Exeter Healthcare NHS Trust
RAL Royal Free Hampstead NHS Trust
RQ6 Royal Liverpool and Broadgreen University Hospitals NHS Trust
RBB Royal National Hospital For Rheumatic Diseases NHS Trust
RRJ Royal Orthopaedic Hospital NHS Trust
RA2 Royal Surrey County Hospital NHS Trust
RD1 Royal United Hospital Bath NHS Trust
RPR Royal West Sussex NHS Trust
RM3 Salford Royal Hospitals NHS Trust
RNZ Salisbury Health Care NHS Trust
RXK Sandwell and West Birmingham Hospitals NHS Trust
RCC Scarborough and North East Yorkshire Health Care NHS Trust
RHQ Sheffield Teaching Hospitals NHS Trust

RK5 Sherwood Forest Hospitals NHS Trust
RXW Shrewsbury and Telford Hospitals NHS Trust
RA9 South Devon Health Care NHS Trust
RM2 South Manchester University Hospitals NHS Trust
RTR South Tees Hospitals NHS Trust
RE9 South Tyneside Health Care NHS Trust
RJC South Warwickshire General Hospitals NHS Trust
RHM Southampton University Hospitals NHS Trust
RAJ Southend Hospital NHS Trust
RTG Southern Derbyshire Acute Hospitals NHS Trust
RVY Southport and Ormskirk Hospital NHS Trust
RJ7 St George's Healthcare NHS Trust
RBN St Helens and Knowsley Hospitals NHS Trust
RJ5 St Mary's NHS Trust
RWJ Stockport NHS Trust
RTP Surrey and Sussex Healthcare NHS Trust
RN3 Swindon and Marlborough NHS Trust
RMP Tameside and Glossop Acute Services NHS Trust
RBA Taunton and Somerset NHS Trust
RBQ The Cardiothoracic Centre - Liverpool NHS Trust
RAS The Hillingdon Hospital NHS Trust
RJ2 The Lewisham Hospital NHS Trust
RBT The Mid Cheshire Hospitals NHS Trust
RTD The Newcastle Upon Tyne Hospitals NHS Trust
RQW The Princess Alexandra Hospital NHS Trust
RPC The Queen Victoria Hospital NHS Trust
RPY The Royal Marsden NHS Trust
RAN The Royal National Orthopaedic Hospital NHS Trust
RL4 The Royal Wolverhampton Hospitals NHS Trust
RKE The Whittington Hospital NHS Trust
RM4 Trafford Healthcare NHS Trust
RA7 United Bristol Healthcare NHS Trust
RWD United Lincolnshire Hospitals NHS Trust
RRV University College London Hospitals NHS Trust
RRK University Hospital Birmingham NHS Trust
RJE University Hospital Of North Staffordshire NHS Trust
RKB University Hospitals Coventry and Warwickshire NHS Trust
RWE University Hospitals Of Leicester NHS Trust
RBK Walsall Hospitals NHS Trust
RET Walton Centre For Neurology and Neurosurgery NHS Trust
RBD West Dorset General Hospitals NHS Trust
RWG West Hertfordshire Hospitals NHS Trust
RFW West Middlesex University NHS Trust
RGR West Suffolk Hospitals NHS Trust
RA3 Weston Area Health NHS Trust
RGC Whipps Cross University Hospital NHS Trust
RN1 Winchester and Eastleigh Healthcare NHS Trust
RBL Wirral Hospital NHS Trust
RWP Worcestershire Acute Hospitals NHS Trust
RPL Worthing and Southlands Hospitals NHS Trust
RRF Wrightington, Wigan and Leigh NHS Trust
RCB York Hospitals NHS Trust

Trust code	Trust name
5A1	New Forest PCT
5A2	Norwich PCT
5A3	South Gloucestershire PCT
5A4	Havering PCT
5A5	Kingston PCT
5A7	Bromley PCT
5A8	Greenwich PCT
5A9	Barnet PCT
5AA	South Manchester PCT
5AC	Daventry and South Northamptonshire PCT
5AF	North Peterborough PCT
5AG	South Peterborough PCT
5AH	Tendring PCT
5AJ	Epping Forest PCT
5AK	Southend On Sea PCT
5AL	Central Derby PCT
5AM	Mansfield District PCT
5AN	North East Lincolnshire PCT
5AP	Newark and Sherwood PCT
5AT	Hillingdon PCT
5AW	Airedale PCT
5C1	Enfield PCT
5C2	Barking and Dagenham PCT
5C3	City and Hackney PCT
5C4	Tower Hamlets PCT
5C5	Newham PCT
5C9	Haringey Teaching PCT
5CC	Blackburn With Darwen PCT
5CD	North Dorset PCT
5CE	Bournemouth PCT
5CF	Bradford City PCT
5CG	Bradford South and West PCT
5CH	North Bradford PCT
5CK	Doncaster Central PCT
5CL	Central Manchester PCT
5CM	Dartford, Gravesham and Swanley PCT
5CN	Herefordshire PCT
5CP	Hertsmere PCT
5CQ	Milton Keynes PCT
5CR	North Manchester PCT
5CV	South Hams and West Devon PCT
5CW	Torbay PCT
5CX	Trafford South PCT
5CY	West Norfolk PCT
5D1	Solihull PCT
5D2	West Lincolnshire PCT
5D3	Lincolnshire South West Teaching PCT
5D4	Carlisle and District PCT
5D5	Eden Valley PCT
5D6	West Cumbria PCT
5D7	Newcastle PCT

5D8	North Tyneside PCT
5D9	Hartlepool PCT
5DC	Harlow PCT
5DD	Morecambe Bay PCT
5DF	North Hampshire PCT
5DG	Isle Of Wight PCT
5DH	West Wiltshire PCT
5DJ	South Wiltshire PCT
5DK	Newbury and Community PCT
5DL	Reading PCT
5DM	Slough PCT
5DN	Wokingham PCT
5DP	Vale Of Aylesbury PCT
5DQ	Burntwood, Lichfield and Tamworth PCT
5DR	Wyre Forest PCT
5DT	North East Oxfordshire PCT
5DV	Cherwell Vale PCT
5DW	Oxford City PCT
5DX	South East Oxfordshire PCT
5DY	South West Oxfordshire PCT
5E1	North Tees PCT
5E2	Selby and York PCT
5E3	East Yorkshire PCT
5E4	Yorkshire Wolds and Coast PCT
5E5	Eastern Hull PCT
5E6	West Hull PCT
5E7	Eastern Wakefield PCT
5E8	Wakefield West PCT
5E9	Mid-Hampshire PCT
5EA	Chesterfield PCT
5EC	Gedling PCT
5ED	Amber Valley PCT
5EE	North Sheffield PCT
5EF	North Lincolnshire PCT
5EG	North Eastern Derbyshire PCT
5EH	Melton, Rutland and Harborough PCT
5EJ	Leicester City West PCT
5EK	Doncaster East PCT
5EL	Doncaster West PCT
5EM	Nottingham City PCT
5EN	Sheffield West PCT
5EP	Sheffield South West PCT
5EQ	South East Sheffield PCT
5ER	Erewash PCT
5ET	Bassetlaw PCT
5EV	Broxtowe and Hucknall PCT
5EX	Greater Derby PCT
5EY	Eastern Leicester PCT
5F1	Plymouth PCT
5F2	Chorley and South Ribble PCT
5F3	West Lancashire PCT
5F4	Heywood and Middleton PCT
5F5	Salford PCT
5F6	Trafford North PCT
5F7	Stockport PCT

5F8	Bebington and West Wirral PCT
5F9	Southport and Formby PCT
5FA	Ashfield PCT
5FC	Rushcliffe PCT
5FD	East Hampshire PCT
5FE	Portsmouth City PCT
5FF	South West Kent PCT
5FH	Bexhill and Rother PCT
5FJ	Hastings and St Leonards PCT
5FK	Mid-Sussex PCT
5FL	Bath and North East Somerset PCT
5FM	West Of Cornwall PCT
5FN	South and East Dorset PCT
5FP	South West Dorset PCT
5FQ	North Devon PCT
5FR	Exeter PCT
5FT	East Devon PCT
5FV	Mid Devon PCT
5FW	Somerset Coast PCT
5FX	Mendip PCT
5FY	Teignbridge PCT
5G1	Southern Norfolk PCT
5G2	Bracknell Forest PCT
5G3	Windsor, Ascot and Maidenhead PCT
5G4	Chiltern and South Bucks PCT
5G5	Wycombe PCT
5G6	Blackwater Valley and Hart PCT
5G7	Hyndburn and Ribble Valley PCT
5G8	Burnley, Pendle and Rossendale PCT
5G9	North Liverpool PCT
5GC	Luton PCT
5GD	Bedford PCT
5GE	Bedfordshire Heartlands PCT
5GF	Huntingdonshire PCT
5GG	Welwyn Hatfield PCT
5GH	North Hertfordshire and Stevenage PCT
5GJ	South East Hertfordshire PCT
5GK	Royston, Buntingford and Bishop's Stortford PCT
5GL	Maldon and South Chelmsford PCT
5GM	Colchester PCT
5GN	Uttlesford PCT
5GP	Billericay, Brentwood and Wickford PCT
5GQ	Thurrock PCT
5GR	Basildon PCT
5GT	Great Yarmouth PCT
5GV	Watford and Three Rivers PCT
5GW	Dacorum PCT
5GX	St Albans and Harpenden PCT
5H1	Hammersmith and Fulham PCT
5H2	Birkenhead and Wallasey PCT
5H3	Cheshire West PCT
5H4	Central Cheshire PCT
5H5	Eastern Cheshire PCT
5H6	Ellesmere Port and Neston PCT
5H7	Derbyshire Dales and South Derbyshire PCT

5H8	Rotherham PCT
5H9	East Lincolnshire PCT
5HA	Central Liverpool PCT
5HC	South Liverpool PCT
5HD	Preston PCT
5HE	Fylde PCT
5HF	Wyre PCT
5HG	Ashton, Leigh and Wigan PCT
5HH	Leeds West PCT
5HJ	Leeds North East PCT
5HK	East Leeds PCT
5HL	South Leeds PCT
5HM	Leeds North West PCT
5HN	High Peak and Dales PCT
5HP	Blackpool PCT
5HQ	Bolton PCT
5HR	Staffordshire Moorlands PCT
5HT	Dudley South PCT
5HV	Dudley Beacon and Castle PCT
5HW	Newcastle-Under-Lyme PCT
5HX	Ealing PCT
5HY	Hounslow PCT
5J1	Halton PCT
5J2	Warrington PCT
5J3	St Helens PCT
5J4	Knowsley PCT
5J5	Oldham PCT
5J6	Calderdale PCT
5J7	North Kirklees PCT
5J8	Durham Dales PCT
5J9	Darlington PCT
5JA	Hinckley and Bosworth PCT
5JC	Charnwood and North West Leicestershire PCT
5JD	South Leicestershire PCT
5JE	Barnsley PCT
5JF	Bristol North PCT
5JG	Bristol South and West PCT
5JH	Cambridge City PCT
5JJ	South Cambridgeshire PCT
5JK	East Cambridgeshire and Fenland PCT
5JL	Broadland PCT
5JM	North Norfolk PCT
5JN	Chelmsford PCT
5JP	Castle Point and Rochford PCT
5JQ	Ipswich PCT
5JR	Suffolk Coastal PCT
5JT	Central Suffolk PCT
5JV	Waveney PCT
5JW	Suffolk West PCT
5JX	Bury PCT
5JY	Rochdale PCT
5K1	South Somerset PCT
5K2	Taunton Deane PCT
5K3	Swindon PCT
5K4	Kennet and North Wiltshire PCT

5K5	Brent PCT
5K6	Harrow PCT
5K7	Camden PCT
5K8	Islington PCT
5K9	Croydon PCT
5KA	Derwentside PCT
5KC	Durham and Chester-Le-Street PCT
5KD	Easington PCT
5KE	Sedgefield PCT
5KF	Gateshead PCT
5KG	South Tyneside PCT
5KH	Hambleton and Richmondshire PCT
5KJ	Craven, Harrogate and Rural District PCT
5KK	Scarborough, Whitby and Ryedale PCT
5KL	Sunderland Teaching PCT
5KM	Middlesbrough PCT
5KN	Langbaurgh PCT
5KP	East Elmbridge and Mid Surrey PCT
5KQ	East Surrey PCT
5KR	North and East Cornwall PCT
5KT	Central Cornwall PCT
5KV	Poole PCT
5KW	Cheltenham and Tewkesbury PCT
5KX	West Gloucestershire PCT
5KY	Cotswold and Vale PCT
5L1	Southampton City PCT
5L2	Maidstone Weald PCT
5L3	Medway PCT
5L4	Swale PCT
5L5	Guildford and Waverley PCT
5L6	North Surrey PCT
5L7	Woking PCT
5L8	Adur, Arun and Worthing PCT
5L9	Western Sussex PCT
5LA	Kensington and Chelsea PCT
5LC	Westminster PCT
5LD	Lambeth PCT
5LE	Southwark PCT
5LF	Lewisham PCT
5LG	Wandsworth PCT
5LH	Tameside and Glossop PCT
5LJ	Huddersfield Central PCT
5LK	South Huddersfield PCT
5LL	Ashford PCT
5LM	Canterbury and Coastal PCT
5LN	East Kent Coastal PCT
5LP	Shepway PCT
5LQ	Brighton and Hove City PCT
5LR	Eastbourne Downs PCT
5LT	Sussex Downs and Weald PCT
5LV	Northamptonshire Heartlands PCT
5LW	Northampton PCT
5LX	Fareham and Gosport PCT
5LY	Eastleigh and Test Valley South PCT
5M1	South Birmingham PCT

5M2	Shropshire County PCT
5M3	Walsall PCT
5M5	South Sefton PCT
5M6	Richmond and Twickenham PCT
5M7	Sutton and Merton PCT
5M8	North Somerset PCT
5M9	Rugby PCT
5MA	Crawley PCT
5MC	Horsham and Chanctonbury PCT
5MD	Coventry PCT
5ME	North Stoke PCT
5MF	South Stoke PCT
5MG	Oldbury and Smethwick PCT
5MH	Rowley Regis and Tipton PCT
5MJ	Wednesbury and West Bromwich PCT
5MK	Telford and Wrekin PCT
5ML	East Staffordshire PCT
5MM	Cannock Chase PCT
5MN	South Western Staffordshire PCT
5MP	North Warwickshire PCT
5MQ	South Warwickshire PCT
5MR	Redditch and Bromsgrove PCT
5MT	South Worcestershire PCT
5MV	Wolverhampton City PCT
5MW	North Birmingham PCT
5MX	Heart Of Birmingham Teaching PCT
5MY	Eastern Birmingham PCT
5NA	Redbridge PCT
5NC	Waltham Forest PCT
TAC	Northumberland Care Trust
TAG	Witham, Braintree and Halstead Care Trust
TAK	Bexley Care Trust

Healthcare Commission

Local Health Services
Primary Care Trust Survey 2004

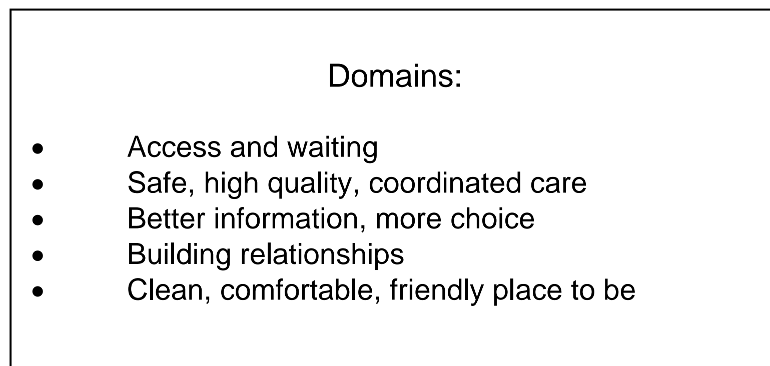
1. Introduction

This document outlines the method used by the Healthcare Commission to group and score the performance indicator questions included within the Local Health Services survey, carried out by Primary Care trusts in Spring 2004.

2. Domains: Selected indicator questions

The Primary Care trust core survey consists of 55 pre-coded questions, and a section for further comments. Of these, 36 questions were allocated to one of the Department of Health patient experience domains (see Figure 2.1).

Figure 2.1: Domains of patient experience



The criteria listed in Figure 2.2 were used to assess the suitability of each individual question, in terms of its viability as an indicator of performance. Using these criteria 23 questions were selected as performance indicators. See Appendix 1 for the questions included within each domain.

Figure 2.2 Criteria for selecting performance indicator questions:

- Patient priorities:

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

- Wide range of issues within domains:

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

- Overlap:

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

- Ease of evaluating responses:

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

- Non-response:

  Questions should have low numbers of missing responses

3. Scoring: Individual indicator questions

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

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

For example, question C3 (see Figure 3.1) asks the respondent whether they were given enough time to discuss their health or medical problem with the doctor. The option of "No" has been allocated a score of 0, as this suggests that improvements to

the patient experience are required. A score of 100 has been assigned to the option "Yes, definitely" as it reflects a positive patient experience. The remaining option, "Yes, to some extent", has been assigned a score of 50 as the patient felt that they were given time to discuss these issues, although not a sufficient amount. Hence it has been placed on the midpoint of the scale.

If the patient reported they did not need to discuss anything this would be classified as a "missing" response, as this option is not a direct measure of whether or not the person was given enough time for discussion.

Figure 3.1 Scoring example: Question C3

C3. Were you given enough time to discuss your health or medical problem with the doctor?	
Yes, definitely	100
Yes, to some extent	50
No	0
I did not need to discuss anything	M

Where a number of options lie between the negative and positive responses, they are placed in appropriate positions along the scale. For example, question B2 asks the respondent to rate the courtesy of the receptionist on arrival at the GP surgery (see Figure 3.2). The following response options were provided:

- Excellent
- Very good
- Good
- Fair
- Poor
- Very poor

A score of 100 is assigned to a response that it was excellent, as this is best practice in terms of patient experience. A response that it was very poor is given a score of 0, and so the remaining four answers are assigned a score that reflects their position in terms of best practice, spread evenly across the scale. Hence the option "very good" has been assigned a score of 80, "good" will score 60, "fair" will score 40, and the response that the courtesy of the receptionist was "poor" will achieve a score of 20 for the trust.

Figure 3.2 Scoring example: Question B2

B2. When you arrived, how would you rate the courtesy of the receptionist?	
Excellent	100
Very good	80
Good	60
Fair	40
Poor	20
Very poor	0

4. Methodology: Overall domain scores

The scores for each domain per trust are calculated using the following method, described according to each stage.

To summarise, age-by-sex weightings are calculated to adjust for any variation between trusts that results from differences in the age and sex of patients. A weight is 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 is calculated by dividing the sum of weighted scores for all eligible responses by the weighted number of eligible respondents.

The reason for weighting is that younger people and women tend to be more critical in their responses than older people and men. If a trust has 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 as follows:

4.1 Weighted analysis

The first stage of the analysis involves calculating national age-by-sex proportions. It must be noted that the term "national proportion" is used loosely here as it is obtained from pooling the survey data from all trusts, and is 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 each patient was then calculated by subtracting the figure given from 2004. The respondents were then grouped according to the categories shown in Figure 4.1.1.

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

The national age-by-sex proportions relate to the proportion of males and females within each age group. In regard to the PCT survey, as shown in Figure 4.1.1, the proportion of males aged 51-65 years is 0.1256631, the proportion of females aged 51-65 years is 0.1569192, etc.

Figure 4.1.1 National Proportions (PCTs)

Sex	Age Group	National Proportion
Male	≤35	.0695936
	36-50	.0970021
	51-65	.1256631
	66-80	.0971822
	81+	.0224802
Female	≤35	.1275296
	36-50	.1526623
	51-65	.1569192
	66-80	.1135143
	81+	.0374533

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 are 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 low proportion of males aged between 51 and 65 years within Trust A responded to the survey, in comparison to 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 patients 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)
Male	≤35	.0695936	0.036	1.933
	36-50	.0970021	0.070	1.385
	51-65	**.1256631**	**0.094**	**1.336**
	66-80	.0971822	0.171	0.568
	81+	.0224802	0.190	0.118
Female	≤35	.1275296	0.090	1.416
	36-50	.1526623	0.116	1.316
	51-65	.1569192	0.121	1.296
	66-80	.1135143	0.101	1.123
	81+	.0374533	0.011	3.404

Likewise, if a considerably higher proportion of females aged between 36 and 50 from Trust B responded to the survey (see Figure 4.1.3), then this group would be

over-represented within the sample, compared to 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. However, Weights are capped at 5.

Figure 4.1.3 Proportion and Weighting for Trust B

Sex	Age Group	National Proportion	Trust B Proportion	Trust B Weight (National/Trust B)
Male	≤35	.0695936	0.033	2.108
	36-50	.0970021	0.059	1.644
	51-65	.1256631	0.125	1.005
	66-80	.0971822	0.127	0.765
	81+	.0224802	0.103	0.218
Female	≤35	.1275296	0.068	1.875
	36-50	**.1526623**	**0.181**	**0.843**
	51-65	.1569192	0.060	2.615
	66-80	.1135143	0.124	0.915
	81+	.0374533	0.120	0.312

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 corresponds to an individual patient, and each column relates to a performance indicator question. For those questions that the patient did not answer (or received a missing score for), the relevant cell remains empty. Alongside these are the weightings allocated to each patient (see Figure 4.2.1).

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

Respondent	Question:				Weight
	B2	B5	C7	H1	
1	100	100	50	100	1.933
2	80	100	100	.	1.416
3	.	.	100	67	1.316

Patients' 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 (PCT)

Patient	Numerators:				Weight
	B2	B5	C7	H1	
1	193.3	193.3	96.65	193.3	1.933
2	113.28	141.6	141.6	.	1.416
3	.	.	131.6	88.172	1.316

4.3 Obtaining the denominators for each domain score

A second dataset was then created. This contained a column for each question, grouped into domains, and again with each row corresponding to an individual respondent. A value of one was entered for the questions whereby a response had been given by the patient, and all questions that had been left unanswered or allocated a scoring of "missing" (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 (PCT)

Respondent	Question:				Weight
	B2	B5	C7	H1	
1	1	1	1	1	1.933
2	1	1	1	.	1.416
3	.	.	1	1	1.316

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 patient had answered (see Figure 4.3.2). Again, the cells relating to the questions that the patient did not answer (or received a "missing" score for) remained set to missing.

Figure 4.3.2 Denominators for "Clean, comfortable, friendly place to be" domain, Trust A (PCT)

Patient	Denominators:			
	B2	B5	C7	H1
1	1.933	1.933	1.933	1.933
2	1.416	1.416	1.416	.
3	.	.	1.316	1.316

4.4 Final calculation

The final score for each domain was calculated by dividing the sum of the weighted scores for all eligible responses within the domain (i.e. numerators) by the weighted sum of all eligible respondents to the questions within each domain (i.e. denominators).

Using the example of Trust A, the domain score based on the data from the three respondents would be calculated as follows:

$$\frac{193.3 + 193.3 + 96.65 + 193.3 + 113.28 + 141.6 + 141.6 + 131.6 + 88.172}{1.933 + 1.933 + 1.933 + 1.933 + 1.416 + 1.416 + 1.416 + 1.316 + 1.316} = 88.475$$

Therefore, a set of five scores would be derived from the results of each trust, relating to each of the five domains.

4.5 Statistical techniques used in the patient survey performance indicators

Calculation of the Z_D scores

For the 2003/04 star ratings, a new method has been used to band many of the indicators. Fundamentally, this method is based on a process of standardisation where a Z_D score is calculated for each trust which relates to the difference between the trust score, and the national mean score of all trusts. This has been done for all the patient survey based indicators, and it allows the combination of scores from two surveys, although this is only done in the case of the young patients and adult inpatient surveys.

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 is 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 significantly 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 domain

Access and Waiting
A2. The last time you saw a doctor from your GP surgery did you have to wait for an appointment? [i.e. how long did you wait?] A3. How do you feel about the length of time you had to wait for an appointment? B4. How long after your appointment time did you have to wait to be seen? H2. In the last 12 months, have you ever been put off going to your GP surgery/health centre because the opening times are inconvenient for you?

Safe, high quality, coordinated care
C6. Did you have confidence and trust in the doctor? D7. In the last 12 months, have you seen anyone at your GP surgery to check how you are getting on with this medicine (i.e. have your medicines been reviewed)? J7. Did you have confidence and trust in the dentist? K4. In the last 12 months have you had your blood pressure taken by anyone from your GP surgery/health centre?

Better information, more choice
C4. Were you involved as much as you wanted to be in decisions about your care and treatment [when you last saw a doctor]? C5. Did the doctor explain the reasons for any treatment or action in a way that you could understand? D2. Were you involved as much as you wanted to be in decisions about the best medicine for you? D4. Were you given enough information about any side-effects the medicine(s) might have? E3. Did someone explain the results in a way you could understand? G3. Were you involved as much as you wanted to be in decisions about your care and treatment [when you last saw a health professional who is not a doctor]? G4. Did [the other health professional] explain the reasons for any treatment or action in a way that you could understand?

Better information, more choice
J5. Did the dentist explain the reasons for any treatment or action in a way that you could to understand?

Building relationships
C2. Did the doctor listen carefully to what you had to say?
C3. Were you given enough time to discuss your health or medical problem with the doctor?
C8. If you had questions to ask the doctor, did you get answers that you could understand?

Clean, comfortable, friendly place to be
B2. When you arrived, how would you rate the courtesy of the receptionist?
B5. Did someone tell you how long you would have to wait [in GP reception]?
C7. Did the doctor treat you with respect and dignity?
H1. In your opinion, how clean is the surgery/health centre?

Appendix 2: Scoring of individual indicator questions

A2. The last time you saw a doctor from your GP surgery did you have to wait for an appointment? [i.e. how long did you wait?]	
No, I was seen without an appointment	100
I was seen on the same working day	100
I had to wait 1 or 2 working days	50
I had to wait more than 2 working days	0
It was a pre-planned appointment or visit	M
Can’t remember	M

A3. How do you feel about the length of time you had to wait for an appointment?	
I was seen as soon as I thought was necessary	100
I should have been seen a bit sooner	50
I should have been seen a lot sooner	0

B2. When you arrived, how would you rate the courtesy of the receptionist?

Excellent	100
Very good	80
Good	60
Fair	40
Poor	20
Very poor	0

B4. How long after your appointment time did you have to wait to be seen?

I did not have an appointment	M
Seen on time or early	100
Waited up to 15 minutes	66
Waited 16-30 minutes	33
Waited 31 minutes or longer	0
Can't remember	M

B5. Did someone tell you how long you would have to wait [in GP reception]?

Yes	100
No, but I would have liked to have been told	0
No, but I did not mind	M
Not sure/ Can't remember	M

C2. Did the doctor listen carefully to what you had to say?

Yes, definitely	100
Yes, to some extent	50
No	0

C3. Were you given enough time to discuss your health or medical problem with the doctor?

Yes, definitely	100
Yes, to some extent	50
No	0
I did not need to discuss anything	M

C4. Were you involved as much as you wanted to be in decisions about your care and treatment [when you last saw a doctor]?

Yes, definitely	100
Yes, to some extent	50
No	0

C5. Did the doctor explain the reasons for any treatment or action in a way that you could understand?	
Yes, definitely	100
Yes, to some extent	50
No	0
I did not need an explanation	M
No treatment or action was needed	M

C6. Did you have confidence and trust in the doctor?	
Yes, definitely	100
Yes, to some extent	50
No	0

C7. Did the doctor treat you with respect and dignity?	
Yes, all of the time	100
Yes, some of the time	50
No	0

C8. If you had questions to ask the doctor, did you get answers that you could understand?	
Yes, definitely	100
Yes, to some extent	50
No	0
I did not need to ask any questions	M
I did not have an opportunity to ask questions	M

D2. Were you involved as much as you wanted to be in decisions about the best medicine for you?	
Yes, definitely	100
Yes, to some extent	50
No	0

D4. Were you given enough information about any side-effects the medicine(s) might have?	
Yes, enough information	100
Some, but I would have liked more	50
I got no information, but I wanted some	0
I did not want/need any information	M
Don't know/ Can't say	M

D7. In the last 12 months, have you seen anyone at your GP surgery to check how you are getting on with this medicine (i.e. have your medicines been reviewed)?	
Yes	100
No	0
Don't know/ Not sure	M

E3. Did someone explain the results in a way you could understand?	
Yes, definitely	100
Yes, to some extent	50
No	0
I am still waiting for the results	M
Not sure/ Can't remember	M

G3. Were you involved as much as you wanted to be in decisions about your care and treatment [when you last saw a health professional who is not a doctor]?	
Yes, definitely	100
Yes, to some extent	50
No	0
No decisions had to be made	M

G4. Did [the other health professional] explain the reasons for any treatment or action in a way that you could understand?	
Yes, completely	100
Yes, to some extent	50
No	0
I did not need an explanation	M
No treatment or action was needed	M

H1. In your opinion, how clean is the surgery/health centre?	
Very clean	100
Fairly clean	67
Not very clean	33
Not at all clean	0
Can't say	M

H2. In the last 12 months, have you ever been put off going to your GP surgery/health centre because the opening times are inconvenient for you?	
Yes, often	0
Yes, sometimes	50
No	100

J5. Did the dentist explain the reasons for any treatment or action in a way that you could understand?	
Yes, completely	100
Yes, to some extent	50
No	0
I did not need an explanation	M
No treatment or action was needed	M

J7. Did you have confidence and trust in the dentist?	
Yes, completely	100
Yes, to some extent	50
No	0

K4. In the last 12 months have you had your blood pressure taken by anyone from your GP surgery/health centre?	
Yes	100
No	0
Not sure/ Can't remember	M

Appendix 3

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 2003/04 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 were 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 2003/04 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 (I $\times \hat{\phi}$) is less than (I - 1) 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:

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

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:

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

For a worked example using this method, please refer to the 'explanation of statistical methods' document in the 'more information' section of the 2003/04 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.

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[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

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* 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:

Patients

- 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?

Trusts

- 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:

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

---

[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.

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, 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: PRIMARY CARE TRUST (PCT) SURVEY 2004

About the survey

The PCT Survey 2004 is part of the NHS Patient Survey Programme, initiated by the Department of Health and now the responsibility of the Healthcare Commission (CHAI). More than 122,000 patients from 303 NHS trusts in England participated in this survey. The survey was designed to provide actionable feedback to each participating trust on patients' views of the care they had received, as well as providing CHAI with patient focused indicators to feed into the 2004 performance ratings for acute and specialist NHS trusts. Further details of the survey methodology can be found in the separate note on the website.

About the benchmarking reports

Each report presents question level results for an individual trust. The PCT questionnaire contained 55 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=4006196&chk=zDBTX5

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

The questionnaire and scores given to each response can be found at:
http://www.healthcarecommission.org.uk/assetRoot/04/00/67/04/04006704.pdf

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

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

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

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

NHS trust-based patient surveys:

Primary Care Trusts
Survey of Local Health Services

Listening to your patients

Last updated 12 December 2003

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

http://www.NHSSurveys.org

Contacts

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

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

Updates

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

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

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1 Introduction: patient feedback and the NHS Plan

1.1 The Commission for Health Improvement

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

1.2 Why we need patient feedback

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

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

1.3 Patient feedback and the NHS Plan

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

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

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

1.4 Performance indicators

Information drawn from the core questions of the Local Health Services Survey will be used by CHI/CHAI to create headline NHS Performance Indicators. These indicators will be used in Primary Care Trust Performance Ratings, due for publication in summer 2004.

In addition to the performance indicators, CHI/CHAI 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 Primary Care Trust to carry out a patient survey in a consistent way, CHI is building up a detailed picture across the country of patients' experiences in NHS trusts. Also, by repeating the same surveys on an annual basis, trusts will be able to monitor their own performance over time.

1.5 Basic requirements for NHS Trust Local Health Services Surveys

In order for comparisons between and within trusts to be accurate, fair and effective, it is essential that the surveys be carried out using a standard procedure in all NHS Primary Care 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 **16th January 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 the survey's progress (e-mail: primarycare.data@pickereurope.ac.uk).
- A postal questionnaire survey must be carried out.
- The sampling procedure set out in this guidance must be followed.
- The questionnaire must be sent to a random sample of 850 adults registered with GP Practices within your PCT. On your request, this sample will be supplied by the NHAIS (NHS Health Authority Information System) or *Exeter system* with whom the majority of your patients are registered.
- The questionnaire must include the 55 core questions. See Section 11 - *The core questions and question bank.*
- The response rate should be at least 50%. That is, you should get 425 returned questionnaires from the 850 mailed out. Three mailings will be necessary to achieve this target.
- The data from the core questions in the Local Health Services Survey, and the required information about the patient sample, must be submitted to the Survey Advice Centre in the form outlined in Section 14.5 - *Submitting data to the Patient Survey Advice Centre* by **7th May 2004**.
- Two copies each of the questionnaire you used, and the covering letters for **each mailing** must be submitted to the Survey Advice Centre in the form outlined in 14.5 - *Submitting data to the Patient Survey Advice Centre* by **7th May 2004**.
- The data must be checked carefully for errors before submitting it to the Advice Centre. See Section 14 - *Entering data.*
- You must keep paper copies (or scanned pictures of the full questionnaires, including the front page) of all questionnaires returned to you until 31st August 2004 but please **do not** send these to the Advice Centre.

1.6 How to use this guide

Trusts have the option of conducting the survey in house or using an approved contractor (see Section 3). Whichever route you take, you will need to address the guidance in Sections 1 to 11 and 15 to 16. Sections 12, 13 and 14 cover the practicalities of mailing out the survey, following-up responses and processing the results. These sections will be most relevant to approved contractors, or trusts undertaking the surveys themselves.

2 Setting up a project team

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

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

3 Approved Survey Contractor versus in-house surveys

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

- Costs
- Quality and confidence in the findings
- Timing
- Human resources
- Comparing organisations within your trust

3.1 Costs

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

Staff time

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

Materials

Stationery and postage

You will need to cover stationery and postage for three mailings. The first mailing will go out to 850 patients and second and third mailings will be sent only to non-responders. (See Section 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 more 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 more 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.

3.5 Comparing organisations 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 organisations 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 Section 9, 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 will need to send only the data from the 850 patients sampled according to these guidelines to the Advice Centre.

When you have decided who will carry out your survey, you must inform the Advice Centre. The deadline for this is 16th January 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

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

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

http//:www.NHSSurveys.org

Ipsos-RSL

Contact: Sam McGuire

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

Maritz

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

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

Market Research UK

Contact: Craig Taylor; Jo Cleaver; Rachel Cope

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

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

Marketing Sciences

Contact: Eileen Sutherland

Marketing Sciences
8 Clement Street
Winchester
Hants
SO23 9DR

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

Market & Opinion Research International (MORI)

Contacts: Tim Jennings, Mark Gill

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

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

MSB Ltd

Contact: Stephen Harwood

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

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

NFO System Three

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

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

NOP

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

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

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

Website: www.nop.co.uk

ORC International

Contact: Geraldine Bailey

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

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

Patient Dynamics

Contact: Andrew Smith

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

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

Picker Institute Europe

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

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

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

PricewaterhouseCoopers

Contact: Dave Ingram, National Project Coordinator – Patient Surveys

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

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

Quality Health

Contact: Dr Reg Race

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

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

Taylor Nelson Sofres

Contact: Susannah Quick or Christine Jamieson

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

Tel: 020 8332 8551/8557
Fax: 020 8332 1090
Email: susannah.quick@tnsofres.com or Christine.jamieson@tnsofres.com
Website: 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 take care that you meet any guarantees of anonymity or confidentiality made in covering letters and on the questionnaire form. Your trust's Caldicott Guardian will be able to advise you on matters of data protection.

5.1 Caldicott

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

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

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

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

5.2 Patients' names and addresses

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

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

1. The contractor delivers pre-packed serial-numbered envelopes containing questionnaires, covering letters and FREEPOST envelopes to the trust. The trust then attaches number-matched address labels to the envelopes and sends them out to patients. Completed questionnaires can then be returned to the contractor and, by checking the Sample Reference 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.

5.3 Points to remember

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

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

5.4 Sample Honorary Contract

[Name of NHS Trust]

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

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

FORM OF ACCEPTANCE

I hereby accept the terms and conditions set out above.

Signed: ……………………………………………………… Date:……………………………..

[Name of employee]

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

[NHS Trust]

13. Date:……………………..

5.5 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, health visitors and other trust staff will not be able to identify individual's 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 be under the care of a particular team, and his or her age, sex and ethnic group are known from their survey responses, it might be possible to use this information to identify them. We would recommend that responses should be aggregated into groups of no less than 30 before data are presented to staff.

5.6 Patient anonymity

In-house surveys

It is important to ensure that any claims you make about 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 responses should be seen by contractor staff only. As long as the response data supplied to trusts do not include the patient identifiers (Sample Reference Numbers) and are not provided to trusts in a way that allows individuals to be identified, it can reasonably be claimed that responses are anonymous.

5.7 Storing completed questionnaires

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

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

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 PCT survey

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

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

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

The development of the survey, covering letters to patients, 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 available in this area.

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

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

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

References

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

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

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

Responsibilities of organisations providing care

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

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

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

7 Collecting data from non-English-speaking populations

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

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

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

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

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

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

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

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

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

8 Timetable

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

Week	Task	See Section
1	**Inform Survey Advice Centre who is carrying out the survey (by 16th January 2004 at the latest).**	3 & 4
1	**Request sample of 850 randomly selected patients from your main NHAIS organisation**	9
1	**Decide on questions to be included in the survey (i.e. select from question bank) or use the Core Questionnaire**	11
1	**Check stocks of headed notepaper**	12
1	**Print questionnaires and covering letters**	12.1 & 13.3
1	**If using an approved contractor, supply them with trust headed paper and a signature of a senior executive and, if appropriate, ensure that the honorary contract is signed**	5.2, 5.4 & 12.2
1	Ensure you have enough headed paper, envelopes, return envelopes and labels	12
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 - 8	**Stick labels on pre-packed numbered questionnaires and reminders supplied by approved contractor (if not using honorary contract)**	0
3	Send out first questionnaires	0
3 - 12	Continue to respond to telephone enquiries	13.2
3 - 12	Continue to book in returned questionnaires	13.5
3 - 12	Enter data	14
5 - 6	Send out first reminders to non-responders	13.6
5 - 6	Be prepared for a small peak in telephone calls as first reminders received	13.2
8	Send out second reminders to non-responders	13.6
11	Complete data entry	14
10-12	Check data for errors ***Very Important***	14.4
12	Send data to Survey Advice Centre by 7th May at the latest	14.5
12	Begin analysing trust's results and writing report	15
13 -	Disseminate results to staff, patients and the public	16

9 The list of patients

For the 2004 Primary Care Trust Survey programme, the list of patients who will take part in the survey will be supplied by the NHAIS organisations that hold the "home" (i.e. not "fringe") patient lists for the PCTs in their area. [2]

9.1 How did our NHAIS organisation draw the sample of patients?

The NHS Information Authority has provided each NHAIS (Exeter) organisation with standard computer programmes that allow them to draw patient samples for each PCT. The following is an outline of that process. This information might be useful to you if responding to patients' questions, or to queries raised when you present the results of the survey to other staff, or when dealing with the NHAIS organisation, but you do not need to understand it in detail.

1. The agency compiles a full list of the "eligible" population for your PCT survey – i.e. all GP-registered patients from your PCT on the database. This count of eligible patients includes patients of either sex between the ages of 16 and 120 (effectively meaning that there is no upper age limit). The technical name of the program used to carry out this procedure is AJ-SURP.

2. The agency takes a random sample of 850 patients from the full list of patients it holds for each "home" PCT. The selection process uses a *random start, fixed interval* sampling method. In short, this means that, having sorted all eligible patients into age order, the program selects a random patient near the beginning of the list, and selects each nth patient after that. This method ensures that the patients selected are representative of the ages of the eligible patients. The technical name of the program used to carry out this procedure is AJ-SURS.

9.2 Can we send out questionnaires to more than the required 850 patients?

It is response *rates*, rather than *numbers* that are of primary importance in this survey. Therefore, it will not improve the accuracy of your results if you send out more than the required 850 questionnaires. The Survey Advice Centre will only accept data from the 850 patients randomly selected by your NHAIS organisation.

If you are interested in comparing groups within your trust, you might want to send out questionnaires to a larger number of patients. However, it is essential that you are able to identify which questionnaires belong to your required 850 patients, and which are "extras". Again, you will only need to send to the Survey Advice Centre the responses received from the 850 patients randomly selected by your NHAIS organisation when they run the standard program for these surveys.

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[2] You will only be asked to take a sample from the patients held by an NHAIS organisation as a "home" Primary Care Trust, not from other NHAIS organisations, who may hold part of your patient list as a "fringe" PCT.

9.3 What do PCTs need to do to obtain their sample of patients?

In order to obtain your patient sample, you need to do the following:

1. Find out which NHAIS organisation holds the data for the majority of your patients – that is, the agency which holds your patient list as a "home" PCT. In most cases, this will be the same as last year.

2. Contact your home NHAIS organisation and ask them to draw a random sample of 850 patients from your list of eligible patients. That is, ask them to run AJ-SURS for your PCT. (They should already have run AJ-SURP for all PCTs.)

3. Tell them how many sets of mailing labels you require. They will supply up to three sets.

4. Tell them how you would like to receive your patient data (by e-mail or on disk). This will depend on your local Data Protection procedures.

9.4 What will the NHAIS organisation provide to the PCT?

The followed items will be supplied:

1. Up to three sets of mailing labels. The address labels will also include the Sample Reference Number you need to match up labels with questionnaire numbers.

2. A comma-separated file comprising "full" patient registration information.

3. An anonymous file in comma-separated variable (CSV) format comprising only the patient details required by the Survey Advice Centre. The following fields are included:

Information included in *full* comma-separated file

The **file header** contains the following values:

- NHAIS System Cipher of the generating database
- National PCT Code
- Date of extract - in the format DDMMYYYY
- Number of patients requested for selection/selected - (Sample Size) – The default is 850
- PCT "eligible" population (as calculated by AJ-SURP)
- Sampling Interval (Number of patients requested for selection divided by PCT "eligible" population)

- Start point for sample (a randomly-selected number between 1 and the Sampling Interval)

Each **patient record** (one record per patient) contains the following fields:

- Sample Reference Number (a unique Reference Number allocated to each patient selected: format "National PCT Code\NHAIS System cipher\4 digit sequence number"
- Patient Title
- First Forename
- Other Forenames
- Surname
- 5 address fields
- Postcode
- Patient's age in years
- Patient's sex
- National Practice code of this patient's GP of Registration

Information included in *anonymous* comma-separated file

The anonymous file contains the following fields for each patient record:

- Sample Reference Number
- Patient's age in years
- Patient's sex

9.5 What if my list contains fewer than 850 patients?

It is possible that, due to small fluctuations in your PCT population, you will receive a list that is one or two patients short of the specified 850 sample size. You do not need to worry about this. However, if you have fewer than 848 patients in your list, you should check again with your NHAIS organisation that the sample has been drawn correctly.

9.6 Deceased patients

You do not need to have the patient list checked for deaths. The standard way of checking whether a patient has died is to send the list to the NHS strategic Tracing Service (NSTS). However, for these PCT surveys, that would not be a useful exercise, since the tracing service would use the same source for their information as the NHAIS organisation. The patient list will only include patients for whom the NHAIS have not been informed of a death.

However, please be aware that this system is not foolproof and the record of a patient's death may not yet have reached the NHAIS system. Also, a few patients may have died in the period between drawing the patient sample and the questionnaire being delivered. Some recently deceased patients might remain in your sample. You need to be prepared for this. Special sensitivity is required when dealing with telephone calls from bereaved relatives.

9.7 Organise the patient information into the sample file

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

Firstly, you will need to add two new columns:

1. 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.

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

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

Table 1 – Sample Excel file of patient details

Sample Reference Number	Title	Forename	Surname	Address1		Address5	Postcode	*Age*	*Sex*	Comments	*Outcome* (of sending questionnaire)
1AB\ABC**0001**	Mrs	Alice	Abbot		--		AB1 1YZ	80	F	Relative called to say that patient had died	3
1AB\ABC**0002**	Mr	Ivor	Ahmed		--		AB2 6XZ	39	M		1
1AB\ABC**0003**	Dr	Janet	Taylor		--		AB4 9NF	56	F		
1AB\ABC**0004**	Miss	Elaine	Fox		--		AB9 6LA	24	F	Questionnaire returned undelivered by post office	2
					--						
1AB\ABC**0849**	Mr	Ranbir	Singh		--		AB4 7MX	76	M		
1AB\ABC**0850**	Ms	F	Young		--		AB9 5ZX	62	F		1

Notes on Table 1

- **Sample Reference Number.** This number is unique for each patient. It can be seen in the example that numbers are in ascending order, starting at 1AB\ABC**0001** at the top of the list. The sampled attendances are numbered consecutively, through to 1AB\ABC**0850** at the bottom of the list. This number will be included on address labels and on questionnaires. Later, when questionnaires are returned (whether completed or not), you (or the Approved Survey Contractor) will be able to use these numbers to monitor which patients have returned their questionnaires and to identify any non-responders, who will need to be sent reminders. If an approved contractor is used, you will need to agree with them on the range of serial numbers that will be used for your patients.

- The **Sample Reference Number, Title**, **Forename**, **Surname**, **Address** fields and **Postcode** are used for printing out address labels. If you wish, you can use the "full" comma-separated file supplied by your NHAIS organisation and the mail merge feature in a word processing package for this purpose. However, your NHAIS organisation will supply you with up to three sets of address labels (for the three mailings).

- **Age** is included so that the ages of those patients who send back questionnaires can be compared with the ages of non-responders. The patient list should only include patients aged between 16 and 120.

- **Gender** is coded as M= male and F = female. However, be aware that other systems may use a different coding.

- The **Comments** column is useful for recording any additional information that may be provided when someone calls the FREEPHONE. They may provide information that a patient has died or is no longer living at this address.

- 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. It can be seen that Dr Taylor and Mr Singh have not yet returned their questionnaires; Mrs Abbot has died since the patient list was first received; Miss Fox's questionnaire was returned undelivered by the post office and Ms Young and Mr Ahmed have returned useable questionnaires.

  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.

9.8 Sharing the patient sample file with an approved contractor

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

9.9 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.

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 call doctors, nurses, patient liaison officers, or the Chief Executive's office with questions 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 GP surgeries and communications with patients before or after their appointments, and in community newsletters. 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 core questions and question bank

Each trust must include in their survey at least the 55 core questions. There is a pre-designed "Core Questionnaire" on the NHSSurveys website, which includes only these questions. In addition, by using the "Create your own survey" option on the website, you can include supplementary questions from a bank of validated questions. These questions will be inserted into the appropriate places within the Core Questionnaire, and the document will then be generated in pdf format, ready for printing.

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

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

1. The **Core Questionnaire**, which comprises 55 questions.

2. The **Enhanced Survey**, which includes all of the 55 core questions, with an additional bank of validated questions.

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

If you design your own questions, it is essential that survey questions be **carefully designed and properly tested** before they are included in a questionnaire. See 18 - *Appendix – Designing and testing new questions.*

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

The surveys can be accessed from the NHSSurveys website:

http://www.NHSSurveys.org

11.1 The Core Questionnaire

The Core Questionnaire consists of 55 questions on 8 pages. These questions cover the issues that have been found to be most important to patients and they must be included in your survey. The front page of the survey explains the purpose of the survey and gives instructions on how to fill it in. In the following pages, the survey questions are divided into sections that broadly follow the patient's experience.

11.2 Using the question bank

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

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

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 is very often under-estimated. For example, it is common for a single question to be re-worded ten or more times before it is considered acceptable. You would need to ensure that you have adequate time to carry out essential research with patients to check that questions are clear, appropriate and unambiguous. You will 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 eight sides of A4 paper.

Number of questionnaires

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

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 1,200 to 1,600 sheets of trust headed notepaper. If an approved contractor is being used to carry out the survey work, it is preferable that the paper does not include a telephone number for the trust, as patients should call the contractor's FREEPHONE line, rather than the trust.

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 Local Health Services 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

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

[Date]

Dear Patient

Local Health Services Survey

We are trying to find out what patients think of the health care services they receive from the National Health Service in their local area. This survey is being carried out by researchers from [NHS Trust name /name of survey company], the Commission for Health Improvement (CHI) 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 and the anonymous survey findings will be analysed by the Advice Centre and CHI.

We are asking you to give us your views by filling in the enclosed short questionnaire. The questionnaire should only take about 20 minutes to complete. A FREEPOST envelope is enclosed. Your views are very important in helping us to find out how well the services work and how they can be improved. This is your chance to help shape and influence how health services are provided in the future.

You have been invited to take part in this survey because you are on the patient register of the [Trust name] Primary Care Trust. We are sending questionnaires to 850 other patients in your area. Your name has been chosen at random, using a computer programme, from a list of all the people registered with GP practices that are part of [Trust Name] Primary Care Trust.

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

If you do decide to take part, please be assured that your answers will be confidential. The questionnaire will be returned to the researchers at [name of survey company or Primary Care Trust]. The researchers will not pass on any information to doctors, nurses or other NHS health care staff in a form that allows individuals to be identified.

If you have any questions or comments or need help with filling out the questionnaire, please do not hesitate to contact [our FREEPHONE/us] on **[phone number]**.

Yours faithfully

[signature]

[print name of signatory]

Chief Executive [or similar]

[NHS Trust name]

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

Common questions and comments

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

Patients should be advised to refer 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. Approved contractors should be given the contact details of the PALS office or an appropriate member of trust staff so that they can refer callers to that person.

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

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

The person to whom the questionnaire is addressed has died.

Even with the use of up-to-date records, it will not be possible to identify all deceased patients, particularly those who have died most recently. It is 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. (See Section 7.)

I do not wish to participate in this survey.

A few patients might call to say that they do not want to be involved in the survey, and fewer still may object to being sent the questionnaire in the first place. Staff should apologise to the patient and reiterate the statement in the covering letter - that the survey is voluntary, and that the patient's care will not be affected in any way by their not responding. It might be helpful to point out the purpose of the survey, and to emphasise the potential value of the patient's responses. If the patient is willing to tell the staff member the identification number written on their survey, it might also be possible to prevent any further reminders being sent to that patient. It is 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 Sample Reference 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 Primary Care Trust Surveys. It should be printed on the trust's letterhead paper. A Word version is on the NHSSurveys website for you to download and add your own trust's details. If you make alterations to it, you will need to seek the approval of your Local Research Ethics Committee (LREC), and to check with the Advice Centre that your changes are acceptable. Two paper copies of the letter you use must be sent to the Advice Centre when you submit your data at the end of the survey.

Covering letter for first mailing

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

[Date]

Dear Patient

Local Health Services Survey

We are trying to find out what patients think of the health care services they receive from the National Health Service in their local area. This survey is being carried out by researchers from [NHS Trust name /name of survey company], the Commission for Health Improvement (CHI) 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 and the anonymous survey findings will be analysed by the Advice Centre and CHI.

We are asking you to give us your views by filling in the enclosed short questionnaire. The questionnaire should only take about 20 minutes to complete. A FREEPOST envelope is enclosed. Your views are very important in helping us to find out how well the services work and how they can be improved. This is your chance to help shape and influence how health services are provided in the future.

You have been invited to take part in this survey because you are on the patient register of the [Trust name] Primary Care Trust. We are sending questionnaires to 850 other patients in your area. Your name has been chosen at random, using a computer programme, from a list of all the people registered with GP practices that are part of [Trust Name] Primary Care Trust.

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

If you do decide to take part, please be assured that your answers will be confidential. The questionnaire will be returned to the researchers at [name of survey company or Primary Care Trust]. The researchers will not pass on any information to doctors, nurses or other NHS health care staff in a form that allows individuals to be identified.

If you have any questions or comments or need help with filling out the questionnaire, please do not hesitate to contact [our FREEPHONE/us] on **[phone number]**.

Yours faithfully

[signature]

[print name of signatory]

Chief Executive [or similar]

[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 Sample Reference 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:

1. A questionnaire numbered with the Sample Reference Number. The number must match (or correspond to) the number on the address label and the number on the list of patient details.

2. A covering letter.

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

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

Postage

Note

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

Approved contractors – no honorary contract

If an approved contractor is carrying out most of the work, they should send pre-packed questionnaires to the trust for mailing out. The envelopes should be clearly marked with the Sample Reference Number so that trust staff can match these with their patient list and put on appropriate 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 Sample Reference 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 the full questionnaires, including the front page) of any questionnaires that are returned to you until 31st August 2004, but please **do not** send these to the Advice Centre.

Approved contractors

If an approved contractor carries out the work, questionnaires will be returned directly to them, so they will be able to record these returns against the list of Sample Reference 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. 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 the NHS Trust Primary Care Health Surveys is 50%. In order to achieve this, you will need to send out two reminders to non-responders.

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

Working with approved contractors

When reminders are due to be sent out, survey contractors should send the pre-packed envelopes bearing the Sample Reference Numbers of the non-responders to the trust. Again, the envelopes should be clearly marked with the Sample Reference 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.

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

First reminder

Text in square brackets needs to be edited.

[Date]

Local Health Services Survey

Approximately three weeks ago we sent you a questionnaire about local health services provided by [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, and you do not need to give a reason. However, your views are important to us so we would like to hear from you. (The return envelope you were sent with the questionnaire does not need a stamp.)

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

If you have any queries about the survey, please call [us/our FREEPHONE] on **[Number]** between [times], [days e.g. Monday to Friday].

Chief Executive [or similar]

[NHS Trust Name]

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 Sample Reference Number. The number must match the number on the address label and the number on the list of patient details.

2. A covering letter.

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

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

Covering letter for second reminder

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

[Date]

Dear Patient

Local Health Services Survey

Enclosed is a copy of a patient survey about your local health services. We originally sent the survey to you a few weeks ago. **Your views are very important in helping us to find out how well the services works and how they can be improved, so we would like to hear from you.** If you have already replied, please ignore this letter and accept our apologies.

We are asking you to give us your views by filling in the enclosed short questionnaire. The questionnaire should only take about 15 to 20 minutes to complete. A FREEPOST envelope is enclosed.

This survey is part of our commitment, outlined in the NHS Plan, to design a health service around the patient. The survey is being carried out by researchers from [NHS Trust name /name of survey company], the Commission for Health Improvement (CHI) 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 and the anonymous survey findings will be analysed by the Advice Centre and CHI. This is your chance to help shape and influence how health services are provided in the future.

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

You have been invited to take part in this survey because you are on the patient register of the [Trust name] Primary Care Trust. We are sending questionnaires to 850 other patients in your area. Your name has been chosen at random, using a computer programme, from a list of all the people registered with GP practices that are part of [Trust Name] Primary Care Trust.

If you do decide to take part, please be assured that your answers will be confidential. The questionnaire will be returned to the researchers at [name of survey company or Primary Care Trust]. The researchers will not pass on any information to doctors, nurses or other NHS health care staff in a form that allows individuals to be identified.

If you have any questions or comments or need help with filling out the questionnaire, please do not hesitate to contact [our FREEPHONE/us] on **[phone number]**.

Yours faithfully

[signature]

[print name of signatory]

Chief Executive [or similar]

[NHS Trust name]

14 Entering data

The data must be submitted to the Advice Centre in the appropriate format by the deadline on 7th May 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 Questionnaire

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

http://www.NHSSurveys.org/

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

- Each row records one patient's responses to the survey.
- For each question, the small number next to the box ticked by the patient should be entered as the response
- If a response is missing for any reason, it should be left blank, or coded as a full stop (.). [3]
- 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.

[3] 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 Advice Centre

You will need to send the data for **only** the 55 compulsory core questions to the Advice Centre. In order to do this, you will need to include those columns of data that cover the responses to those 55 questions to the pre-designed Excel file available on the website. The columns of this standard Excel file are headed with the numbers corresponding to the question numbers in the Core Questionnaire. They also include the wordings of the 55 core questions so that you can match up questions from Enhanced Surveys with the core questions.

14.4 Checking the data for errors

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

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

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

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

14.5 Submitting data to the Patient Survey Advice Centre

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

File format

- Microsoft Excel Worksheet (*not* Workbook). Any version of the software is acceptable.
- File name must be in the format <NHSTrustName>_PCT2004.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 (.). [4]

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[4] Data may be missing because the patient skipped a question or set of questions by following instructions. Alternatively, a patient may have not answered for some other reason. However, all missing data should be left blank or coded as a 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
Sample Reference Number	1AB\ABC\NNNN		The unique reference number allocated to each patient by the NHAIS organisation
Age	NN or NNN		Age in years
Gender	M or F	**M** = Male **F** = Female	If gender is not known or unspecified, this field should be left blank or coded as a full stop (.).
Outcome	N	1 = Returned useable questionnaire 2 = Returned undelivered by the mail service or patient moved house 3 = Patient died 4 = Patient reported too ill to complete questionnaire, opted out or returned blank questionnaire 5 = Patient was not eligible to fill in questionnaire 6 = Questionnaire not returned (reason not known)	Remember to fill in all the blank cells with 6s when the survey is complete.
Responses to each of the ** 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, details that allow individuals to be identified must not be sent to the Survey Advice Centre.

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

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

Patient Sample Information				*Patient Response Information*								
Sample Reference Number	***Age***	***Sex***	***Outcome***	***A1***	***A2***	***A3***	--	***L1***	***L2***	***L3***	***L4***	***L5***
1AB\ABC**0001**	80	F	4									
1AB\ABC**0002**	39	M	1	1	2			1	1965	2	2	11
1AB\ABC**0003**	56	F	6									
1AB\ABC**0004**	24	F	2									
1AB\ABC**0847**	65	F	1	1	5			2	1939	1	3	1
1AB\ABC**0848**	18	F	1	2				2	1986	4	2	1
1AB\ABC**0849**	76	M	6									
1AB\ABC**0850**	62	F	1	1	2			2		2	1	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 copy of the **checklist** on the next page.

Delivery

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

Local Health Services Surveys
Advice Centre for NHS Patient Survey Programme
Picker Institute Europe
King's Mead House
Oxpens Road
OX1 1RX

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

Date

The data must be supplied by **9th May 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?
1. Check that your **file name** follows the naming convention: <NHSTrustName>_PCT2004.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. Check that all **data are correct**, and that all values are in range.	
4. Send data only for the **850 patients** randomly selected by your NHAIS agency.	
5. 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.	
6. Remove any **passwords**.	
7. Include **two paper copies** of the questionnaire you used.	
8. Include **two paper copies** of the covering letters you used for the first mailing, the second mailing and the third mailing.	
9. Include **contact details of 2 people** who will be available to respond to any queries about the data.	
10. Check that you have included data columns for **all 55 core questions**.	
11. Check that you have **not** included any columns for optional questions.	
12. **Check again** that all data are correct, and that all values are in range! *See note below*.	

Very important

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

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

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 55 core questions are automatically computed and displayed on the other sheets of that Excel workbook, which correspond to the sections of the core Local Health Services Survey (excluding the "Other Comments" section). 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 a staged analysis should be the most general - for example, summary measures or measures of overall performance. The next level should delve into particular issues that underlie the summary measures - performance along particular dimensions of care, for example, or of particular units or staff. The final level should entail statistical or cross-tab analysis to get at the causes of the particular issues.

Group similar questions together to provide summary analysis

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

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

Use statistical tests to make comparisons and subgroup analyses

Statistical tests can be used to examine relationships and associations between groups (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 rate). If tests show that the differences between two groups are not statistically significant, you should view the patterns of responses as only suggestive.

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

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

Use patient feedback data with other data

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

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 waiting for a GP appointment, or if this problem rate 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 CHI and NHSSurveys website to find out where your trust performs better or worse than other trusts.

Compare results over time

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

Compare with predefined goals

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

Correlation with overall measures

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

Predictive value on overall measures (regression analysis)

Similar to correlation, regression analysis also gives a sense of the issues that most sharply affect patients' overall assessments of care. Regression analysis is superior to simple correlation, in that it can adjust for other things that have an impact on the overall measure, and it provides more precise estimates of how overall measures will change in response to improvement on individual items. 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 key stakeholders you will help to ensure they are used effectively and not forgotten.

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

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

Spread the Word

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

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

Promote understanding

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

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

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

Compare departments within your trust

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

Identify where patients report most room for improvement

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

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

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

Identify problems surrounding particular aspects of the patient journey

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

- Being seen and treated by one type of health professional
- Receiving information on tests
- Information on medicines.

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, "Were you given information about the purposes and side effects of medicines?" would be difficult to answer. Respondents could be confused about how they should answer if their experiences of the advice given to them about the purposes of medicines differed from their experiences of the advice they were given about side effects. 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 about the length of time you had to wait?" 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 making an appointment should be put near the beginning of the questionnaire, while questions about advice that might be given at the end of an appointment 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 tests should begin with the filter "Have you had any tests in the last 12 months?" Those who answer "no" to this question are guided to skip the tests section and go straight to the next section. However, complex filters can often confuse respondents, so they should be kept to a minimum.

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 have received from Mental Health Services in the last 12 months?

1 ☐ Excellent

2 ☐ Very good

3 ☐ Good

4 ☐ Fair

5 ☐ Poor

6 ☐ Very poor

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.

Inspecting Informing Improving

Patient survey report 2004

- primary care

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

Introduction

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

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

This is one of five reports published by the Healthcare Commission and Picker Institute Europe that summarise the key findings from the surveys and describe the experiences of patients of each of these services. In 1998 and 2002, the Department of Health carried out general practice surveys. The Commission for Health Improvement carried out the first local health services survey in 2003 and the Healthcare Commission repeated this in 2004.

This report summarises the key findings from the 2004 survey of primary care services, highlighting differences with the 2003 results.

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

Who took part in the survey?

Primary care trusts (PCTs) are responsible for providing access to a wide range of health services. These services are delivered by a team of healthcare professionals based at local health centres or surgeries, including GPs, family doctors, practice nurses, district nurses, midwives and health visitors. PCTs are also responsible for the services provided by NHS dental services and other health services within each local area. Everyone is entitled to register with a GP, and a list of all registered patients is maintained by each PCT.

Each PCT surveyed 850 eligible patients who were registered with one of their practices. Patients were eligible if they were over 16 years old. The respondents were asked to complete the survey by thinking about their most recent contact with local health services, either for themselves or for a child in their care. The sampled patients were sent a postal questionnaire and a covering letter, and up to two reminder letters were sent to non-responders.

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

The 2003 and 2004 survey results were compared on all of the 32 questions that were directly comparable, that is, 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 the differences reported are statistically significant.

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

Questionnaires were sent to 249,538 patients and 122,113 completed questionnaires were returned. This represents a response rate of 49%, once undelivered questionnaires and deceased patients had been accounted for. Response rates varied between trusts from 22% to 64%. This is the same as the overall response rate for the 2003 survey, for which response rates from trusts varied from 26% to 65%.

The survey results show that, of respondents:

- 59% were women
- 21% were aged 16 to 35, 25% 36 to 50 years, 28% 51 to 65 years, 20% 66 to 80 years and 5% 81 or older
- 95% of respondents were white, 1% Asian or Asian British, 2% black or black British, less than 1% mixed race, Chinese or from other ethnic groups
- 59% left full time education aged 16 years or less, 19% were aged 17 to 18 and 18% were aged 19 years or over when they left full time education, and 4% were still in full time education
- 69% of respondents rated their own health as good to excellent in the previous four weeks and 31% very poor, poor or fair

There were significant differences in response rates by age and sex: The highest responding groups were women and men aged between 66 and 80 at 71%. The lowest response rate for any group by age and sex was men aged 16 to 35 at only 24%.

Contact with the surgery

Of the patients who responded to the survey, 88% had visited their local health centre or GP surgery during the previous 12 months.

A small proportion (6%) said that they had often been put off going to their GP surgery in the last 12 months because the opening times were inconvenient, while 16% said this had sometimes put them off. This total of 22% compares with 19% of respondents in 2003 who said inconvenient opening hours had often or sometimes put them off going to their GP surgery.

> "I work full time. Therefore evening or early morning surgeries would be good"

> "… always seem to get an appointment pretty quick and at a time to suit my work"

Accessing health services

It is important to patients that they are given an appointment within a short time of calling their health centre. When they arrive for their appointment they should be treated courteously by the receptionist and, if they have to wait, often prefer to be told how long their wait might be.

Waiting for an appointment

The NHS Plan stated that by December 2004 all patients would be able to be seen by a GP within 48 hours. The survey found that over half of the patients who had been in contact with their doctor during the past 12 months were seen within two working days. Twenty-nine per cent were seen on the same working day and 25% had to wait one or two working days for an appointment. A further 7% of patients were seen without an appointment, and 17% had a pre planned appointment or visit. However, 23% had to wait more than two days.

Between the 2003 and 2004 surveys, the percentage of patients seen on the same working day increased from 16% to 29%. Those who waited one or two working days increased from 15% to 25%. The proportion who waited more than two working days increased from 22% to 23%, but fewer people were seen without an appointment or with a pre-planned appointment or visit.

Over half felt they were given an appointment as soon as they thought was necessary, while 30% felt their appointment should have been a bit sooner, and 13% felt it should have been a lot sooner.

> "Sometimes there is a wait of over a week to make an appointment. Anyone who can wait that long doesn't need to see a doctor!"

> "I can now see my GP in two days instead of two weeks if I ring early enough"

Forty-four per cent of respondents who waited for more than a day for an appointment did so because they were unable to get an earlier appointment with any doctor at their GP surgery. However, 41% said the main reason they had to wait was that they wanted to see their own choice of doctor, and 11% said it was not convenient for them to have an appointment at any other time.

> “I prefer to see the same doctor at each visit because my health record is very complicated”

Surgery waiting times

Of patients who had seen someone from their GP surgery/local health centre during the past 12 months, 24% reported that on their last visit to the surgery, they had been seen on time or early. Forty-seven per cent of patients waited up to 15 minutes after their stated appointment time, giving a total of 71% who were seen within 15 minutes of their stated appointment time. Twenty-two per cent waited between 16 and 30 minutes and 8% waited more than 31 minutes.

A small number of patients were told how long they would have to wait, and 49% were not told, but did not mind. Forty-three per cent were not told, but would have liked to have been.

> “It would be nice to have a vague idea of how long one has to wait”

Surgery: reception

Of the patients that responded, 26% rated the courtesy of the receptionist as excellent when they arrived at the surgery and 59% rated it as either very good (34%) or good (25%). However, 11% of patients rated the courtesy of the receptionist as fair, 2% as poor and 1% as very poor.

> “Receptionist is friendly and helpful”

Over two thirds of patients reported that other patients in the reception area could overhear them talking to the receptionist when they arrived but that they did not mind, and 14% said that other patients in the reception area could not overhear them. However, 18% of patients said they could be overheard by other patients and were not happy about this.

> ”Whoever is talking to the receptionist is very audible and the focus of attention of other waiting patients”

> “You have to talk to the receptionist with a queue of people behind you and within hearing range of waiting patients”

Surgery: cleanliness

Nearly three quarters of patients rated the surgery or health centre as very clean and a further 25% said it was fairly clean. Only 1% thought the surgery was not very clean or not at all clean.

> “Bright, clean pleasant surgery, easily accessible and friendly atmosphere”

Seeing a doctor

Patients should be treated with respect and dignity by the doctor, and it is important that they have trust and confidence in them. Patients should be given enough time to discuss their health problems and be involved as much as possible in decisions about their care and treatment. They should be given good explanations about their treatment, and any questions about it should be answered in a way they can understand.

Of the patients who responded, 85% had seen a doctor during the previous 12 months.

Almost all patients felt that the doctor had treated them with respect and dignity all of the time, 7% of patients felt they were treated with respect and dignity some of the time and 1% felt they were not treated with respect and dignity.

> “My GP doesn’t seem to have much time to talk, but has always treated me as an intelligent human being and not just a name”

> “GPs are very caring. The patients are treated with respect at all times”

Three quarters of patients said they definitely had confidence and trust in the doctor, 21% to some extent, and 3% said they did not have confidence and trust in the doctor.

> “My GP is up to date with research, does not over-prescribe and is interested in trying new treatments”

> “Superb relationship with one particular doctor. This has really been a success in terms of treatment, trust and results”

Sixty-nine per cent said the doctor definitely involved them as much as they wanted to be involved in decisions about their care and treatment. Twenty-seven per cent said they were involved in decisions to some extent, and 5% said they were not involved in decisions as much as they wanted to be.

> “My GP listens and accepts my views and decisions in my own healthcare”

> “Doctors need to discuss their patients’ medical problems with them in an open and informative way”

Communication issues

The survey identified several areas where communication between doctor and patient could be improved. Eighty-two per cent of patients said that the doctor had definitely listened to them, 17% felt that they had listened to some extent and 2% of patients said that the doctor did not listen to what they had to say.

> “Doctors should look at you when they speak to you and, when they ask a question, listen to the reply”

> “Doctors and nurses are very helpful, respectful and listen carefully to any problems”

Almost three-quarters of respondents said they were definitely given enough time to discuss their health or medical problem with the doctor. Twenty-two per cent said they were given enough time to some extent, but 4% said they were not given enough time to discuss their health or medical problem with the doctor.

Three-quarters said they were given an explanation of the reasons for any treatment or action that they could understand completely, but 21% said they were given an explanation that they could understand to some extent and 3% of patients were not given an explanation of the reasons for any treatment or action in a way they could understand.

> “I always have things explained to me about my health and treatment by my doctor. He takes time with me”

> “GPs could explain treatments/illnesses in more detail. They often presume that you understand without explaining the full implications of something”

Of those patients who had questions to ask, 76% said they definitely got answers they could understand from the doctor. Twenty-one per cent were given answers they could understand to some extent, 2% were not given answers that they could understand and 1% of patients did not have an opportunity to ask any questions.

Seeing another healthcare professional

Patients expect to be treated with respect and dignity by other health professionals, and to have good standards of communication with them.

Nearly half of the respondents had seen a healthcare professional other than a doctor from their health centre during the previous 12 months. Of these, 79% had seen a practice nurse or nurse practitioner, 3% had seen a midwife, 5% had seen a district nurse, 3% had seen a health visitor and 10% had seen someone else.

Almost all patients felt that the person they saw had treated them with respect and dignity all of the time. Five per cent of patients felt they were treated with respect and dignity only some of the time and 1% felt they were not treated with respect and dignity.

> “Health visitors are friendly, approachable, helpful and knowledgeable”

> “I am particularly impressed with the support I get from our local district nurses. They are kind, well-informed, very courteous and patient”

Most patients said they definitely had confidence and trust in the last healthcare professional they saw, while 17% said they had to some extent, and 2% said they did not have confidence and trust in that healthcare professional.

> “Universally, the nursing staff are sympathetic and efficient”

> “Health visitor cover has been very poor: missed appointments, poor advice, lack of interest and lack of information”

Survey results for each professional group are given in the appendix.

Communication issues

The survey identified several areas where communication between healthcare professionals and patients could be improved

Patients were asked about the explanations of the reasons for any treatment or action they were given by the healthcare professional they saw. Eighty-two percent said they were given an explanation that they could understand completely. Sixteen per cent said they could only understand it to some extent and 3% of patients were not given an explanation of the reasons for any treatment or action in a way they could understand.

The majority said the healthcare professional they saw involved them as much as they wanted in decisions about their care and treatment, but 18% said they were only involved to some extent, and 3% said they were not involved as much as they wanted to be.

Tests

Patients who need tests should receive good explanations about why they are necessary, how they will be carried out, and of the results.

Over half the patients who had seen someone from their local health centre/GP surgery during the previous 12 months had had tests carried out at the surgery, - for example, blood tests, swabs, smear tests. The survey identified two areas where information about these tests could be improved:

- 81% said that the purpose of their tests had been completely explained, 16% that the purpose had been explained to some extent and 3% that the purpose was not explained in a way they could understand. These figures do not include patients who were still waiting for their test results at the time they responded

Of those patients who had received their test results, 68% said the results had definitely been explained in a way they could understand. Twenty-three per cent said they had been explained to some extent and 9% that they had not been explained in a way they could understand. The percentage who said they had definitely had an explanation they could understand decreased from 72% in 2003 to 68% in 2004.

> “Need a better explanation of test results. My last test result was normal, whatever that means.”

Referrals

Increasingly, patients are given a choice about which hospital they are referred to. It is important that, wherever patients are referred to, the healthcare professional they see has enough information about their treatment or condition.

Over one third of respondents had been referred to another healthcare professional such as a hospital consultant.

Of those patients who had been referred on, 26% were given a choice about which hospital they went to and 58% said they were not given a choice but did not mind. However, 16% said they were not given a choice and would have liked one.

Of those patients who had been seen by another healthcare professional, 63% said the person they saw seemed to have all the necessary information about them and their condition or treatment. Twenty-nine per cent of these patients said the person they saw had the required information to some extent, but 8% said that the person they were referred to did not have all the necessary information about them and their condition.

Medication

Patients should be informed and involved in decisions about their medication. Over half of the survey respondents had been prescribed new medicine including tablets, suppositories and injections by a doctor from their GP surgery/local health centre during the previous 12 months.

Of those patients, 59% said that the last time they were given a new prescription, they were definitely involved as much as they wanted to be in decisions about the best medication for them. Twenty-nine per cent were involved to some extent and 12% were not involved in decisions about their medication as much as they wanted to be. The 59% figure in 2004 compares favourably to 55% in 2003.

The survey identified several issues where the information given to patients about their medication could be improved. Of those patients who were given new prescriptions and who wanted information, 80% said that they were given enough information about the purpose of their medication, 17% were given some but not enough information, and 3% wanted information but were not given any at all. Sixty-one per cent said they were given enough information about any side effects, while 21% were given some information, but not enough, and 18% wanted information but were not given any at all. Eighty-six per cent were given enough information about how to use their new medication, for example, when to take it, how long they should take it for and whether it should be taken with food. However, 11% of patients were not given enough information and 3% said they wanted this information but were not given it. Over half the respondents had been taking some prescribed medication for 12 months or longer. Of those, 76% had seen someone at their GP surgery to have their medication reviewed.

> "Doctors need to explain why they're giving their patients the medication they're giving us."

Health promotion

PCTs have responsibility for improving the health of their populations and reducing health inequalities. Health promotion initiatives have a role to play here.

Almost two thirds of all respondents reported that their blood pressure had been taken by someone at their GP surgery/local health centre during the previous 12 months.

The survey asked patients whether they had been offered a flu jab (influenza vaccination) during the previous 12 months. Of the respondents who were aged 65 or over and who thought they needed a flu jab, 84% had had one. Fourteen per cent said they had been offered a flu jab but didn't want one, and only 2% said they had not been offered one. This 2004 survey showed that 76% of over-65s had a flu jab in 2003, not excluding those who did not think they needed one. This exceeded the Government target of 70% uptake of the flu jab in patients aged 65 and over in 2003/2004[3].

Nearly one fifth of respondents said they smoke cigarettes. Of those, 19% had definitely been given advice or help from their local health service on giving up and 16% had been given advice to some extent. Nineteen per cent said they had not been given help or advice but would have liked some and nearly half said they did not want help or advice.

Dental services

Of all survey respondents, 58% were currently registered with a dentist as an NHS patient, while 21% were registered as a non-NHS patient, and 20% were not registered with any dentist at all. Of those respondents who were not registered with a dentist as an NHS patient, 67% said they would like to be.

> "Definitely need more NHS dentist surgeries. I do not have a dentist due to this problem"

> "There is a terrible lack of NHS dentists. I was forced to go private by my then NHS dentist"

Visiting the dentist

Over half (52%) had visited a dentist as an NHS patient within the previous 12 months. The survey identified some areas where NHS dental services could be improved:

- three quarters of patients had complete confidence and trust in the dentist, but 22% only had confidence and trust to some extent and 3% did not have any confidence and trust in the dentist
- seventy-seven per cent of patients said that staff had definitely done everything they could to help control their pain, 19% that staff had done what they could to control their pain only to some extent, and 4% that staff had not done everything they could to help control their pain
- seventy-seven per cent of patients said that the dentist had explained the reasons for any treatment or action in a way they could understand completely. Twenty per cent of patients said they could understand the explanation they were given to some extent, and 3% did not understand what they were told
- sixty-nine per cent of patients said they were definitely involved as much as they wanted to be in decisions about their dental care and treatment, while 25% said they were involved to some extent and 6% were not involved as much as they wanted to be

While 75% said they were definitely involved as much as they wanted to be in decisions about their care in 2003, by 2004 this had decreased to 69%. In 2003, 77% said they had confidence and trust in their dentist completely, whereas in 2004 that figure was 75%.

Conclusions

This is the second survey involving all primary care trusts in England. It describes the experience of over 120,000 people who use local health services.

Patients were highly satisfied with the amount of time they have in consultations with GPs, and the care they receive from clinical staff. Patients also reported being treated with dignity and respect, being listened to and having confidence and trust in GPs, nurses and dentists. The service from reception staff was also positively rated, although some patients had concerns about being overheard when talking to receptionists, and not being told how long they would need to wait to be seen.

There has been a notable increase in the numbers of patients obtaining GP appointments within two working days, the proportion rising from 31% in 2003 to 54% in 2004. Despite this increase, there remains a discrepancy between the reports from patients, and the official waiting time data that indicates that 97% of patients can see a GP within two working days[4]. The proportion of people who report having been put off going to the GP surgery because of inconvenient opening hours has increased from 20% in 2003 to 22% in 2004.

The 2004 survey found improvements since 2003, but there is still scope for better patient involvement in decisions about care and treatment, particularly decisions about medication and information about side effects.

There has been an encouraging increase in the proportion of over 65s who receive a flu jab, from 76% to 80%. However, of the smokers who would like help and advice to give up, a fifth are not receiving any.

Dental patients report a decline in their involvement in care and the quality of explanations of treatment. Access to NHS dentistry remains a concern: two thirds of people who are not registered with an NHS dentist said that they would like to be.

Appendix: Tables of results

National average results are presented for each question, along with tables comparing respondents and non-respondents, comparisons of results with the 2003 survey, for relevant questions, and selected cross-tabulations.

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

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

However, the information about the demographics (for example age, sex and ethnic group) has not been adjusted in this way, as it is more appropriate to report the actual percentages of these variables, rather than adjusting them for variations among trusts.

Trust based national averages for responses to all questions.

A. Making an appointment

A1. Have you made an appointment with a doctor from your GP surgery/ health centre in the last 12 months?

	National average %	Number
Yes	85	
No	15	
Total specific responses		120964
Missing responses		1149

Answered by all

A2. The last time you saw a doctor from your GP surgery did you have to wait for an appointment?

	National average %	Number
No, I was seen without an appointment	7	
I was seen on the same working day	29	
I had to wait 1 or 2 working days	25	
I had to wait more than 2 working days	23	
It was a pre-planned appointment or visit	17	
Total specific responses		100316
Missing responses		2625
Can't remember		1378

Answered by those who had made an appointment with a GP in the last 12 months

A3. How do you feel about the length of time you had to wait for an appointment with a doctor?

	National average %	Number
I was seen as soon as I thought necessary	58	
I should have been seen a bit sooner	30	
I should have been seen a lot sooner	13	
Total specific responses		47670
Missing responses		2659

Answered by those who had made an appointment with a GP in the last 12 months and who had to wait a day or more for their appointment

A4. What was the main reason you had to wait?

	National average %	Number
I wanted to see my own choice of doctor	41	
I could not get an earlier appointment with any doctor	44	
Not convenient for me to have an appointment earlier	11	
Another reason	4	
Total specific responses		46563
Missing responses		3766

Answered by those who had made an appointment with a GP in the last 12 months and who had to wait a day or more for their appointment

Visiting the GP surgery

B1. Have you visited your GP surgery/ health centre in the last 12 months?

	National average %	Number
Yes	88	
No	12	
Total specific responses		120353
Missing responses		1760

Answered by all

B2. When you arrived, how would you rate the courtesy of the receptionist?

	National average %	Number
Excellent	26	
Very good	34	
Good	25	
Fair	11	
Poor	2	
Very poor	1	
Total specific responses		106673
Missing responses		1587

Answered by those who had visited their GP surgery or health centre in the last 12 months

B3. In the reception area, could other patients overhear what you talked about with the receptionist?

	National average %	Number
Yes, and I was not happy about it	18	
Yes, but I did not mind	68	
No, others could not overhear	14	
Total specific responses		97546
Missing responses		1839
Don't know/can't say		8875

Answered by those who had visited their GP surgery or health centre in the last 12 months

B4. How long after your appointment time did you have to wait to be seen?

	National average %	Number
Seen on time or early	24	
Waited up to 15 minutes	47	
Waited 16-30 minutes	22	
Waited 31 minutes or longer	8	
Total specific responses		97723
Missing responses		2412
I did not have an appointment		5548
Can't remember		2577

Answered by those who had visited their GP surgery or health centre in the last 12 months

B5. Did someone tell you how long you would have to wait?

	National average %	Number
Yes	8	
No, but I would have liked to have been told	43	
No, but I did not mind	49	
Total specific responses		80110
Missing responses		2882
Not sure/can't remember		1915

Answered by those who had visited their GP surgery or health centre in the last 12 months and who either did not have an appointment or were not seen on time

C. Seeing a doctor

C1. Have you seen a doctor from your GP surgery/ health centre in the last 12 months?

	National average %	Number
Yes	85	
No	15	
Total specific responses		120432
Missing responses		1681

Answered by all

C2. Did the doctor listen carefully to what you had to say?

	National average %	Number
Yes, definitely	82	
Yes, to some extent	17	
No	2	
Total specific responses		103007
Missing responses		1421

Answered by those who had seen a doctor from their GP surgery or health centre in the last 12 months

C3. Were you given enough time to discuss your health or medical problem with the doctor?

	National average %	Number
Yes, definitely	74	
Yes, to some extent	22	
No	4	
Total specific responses		101930
Missing responses		1448
I did not need to discuss anything		1050

Answered by those who had seen a doctor from their GP surgery or health centre in the last 12 months

C4. Were you involved as much as you wanted to be in decisions about your care and treatment?

	National average %	Number
Yes, definitely	69	
Yes, to some extent	27	
No	5	
Total specific responses		102383
Missing responses		2045

Answered by those who had seen a doctor from their GP surgery or health centre in the last 12 months

C5. Did the doctor explain the reasons for any treatment or action in a way that you could understand?

	National average %	Number
Yes, completely	75	
Yes, to some extent	21	
No	3	
Total specific responses		97819
Missing responses		1648
I did not need an explanation		3625
No treatment or action was required		1336

Answered by those who had seen a doctor from their GP surgery or health centre in the last 12 months

C6. Did you have confidence and trust in the doctor?

	National average %	Number
Yes, definitely	76	
Yes, to some extent	21	
No	3	
Total specific responses		102920
Missing responses		1508

Answered by those who had seen a doctor from their GP surgery or health centre in the last 12 months

C7. Did the doctor treat you with respect and dignity?

	National average %	Number
Yes, all of the time	92	
Yes, some of the time	7	
No	1	
Total specific responses		102933
Missing responses		1495

Answered by those who had seen a doctor from their GP surgery or health centre in the last 12 months

C8. If you had questions to ask the doctor, did you get answers that you could understand?

	National average %	Number
Yes, definitely	76	
Yes, to some extent	21	
No	2	
I did not have an opportunity to ask questions	1	
Total specific responses		97354
Missing responses		1644
I did not need to ask any questions		5430

Answered by those who had seen a doctor from their GP surgery or health centre in the last 12 months

D. Medications (for example tablets, ointment, oral contraceptives)

D1. In the last 12 months, have you had any new medication(s) prescribed for you?

	National average %	Number
Yes	53	
No	47	
Total specific responses		118916
Missing responses		1748
Can't remember		1449

Answered by all

D2. Were you involved as much as you wanted to be in decisions about the best medication for you?

	National average %	Total
Yes, definitely	59	
Yes, to some extent	29	
No	12	
Total specific responses		62998
Missing responses		2157

Answered by those who had been prescribed new medicines from their GP surgery or health centre in the last 12 months

D3. Were you given enough information about the purpose of the medication?

	National average %	Number
Yes, enough information	80	
Some, but I would have liked more	17	
I got no information, but I wanted some	3	
Total specific responses		60666
Missing responses		1943
I did not want/need any information		1980
Don't know/can't say		566

Answered by those who had been prescribed new medicines from their GP surgery or health centre in the last 12 months

D4. Were you given enough information about any side effects the medication might have?

	National average %	Total
Yes, enough information	61	
Some, but I would have liked more	21	
I got no information, but I wanted some	18	
Total specific responses		52332
Missing responses		2207
I did not want/need any information		8372
Don't know/can't say		2244

Answered by those who had been prescribed new medicines from their GP surgery or health centre in the last 12 months

D5. Were you given enough information about how to use the medication?

	National average %	Number
Yes, enough information	86	
Some, but I would have liked more	11	
I got no information, but I wanted some	3	
Total specific responses		60417
Missing responses		2014
I did not want/need any information		2297
Don't know/can't say		427

Answered by those who had been prescribed new medicines from their GP surgery or health centre in the last 12 months

D6. Have you been taking any prescribed medication(s) for 12 months or longer?

	National average %	Number
Yes	53	
No	47	
Total specific responses		120050
Missing responses		2063

Answered by all

D7. In the last 12 months, have you seen anyone at your GP surgery to check how you are getting on with this medication?

	National average %	Number
Yes	76	
No	24	
Total specific responses		62497
Missing responses		2323
Don't know/not sure		1657

Answered by those who had been taking any prescribed medicine for 12 months or longer

E. Tests

E1. In the last 12 months, have you had any tests carried out by anyone from your health centre?

	National average %	Number
Yes	54	
No	46	
Total specific responses		119004
Missing responses		1630
Can't remember		1479

Answered by all

E2. Was the purpose of the test(s) explained in a way you could understand?

	National average %	Number
Yes, completely	81	
Yes, to some extent	16	
No	3	
Total specific responses		63531
Missing responses		1867
Not sure/can't remember		383

Answered by those who had had a test carried out by someone from their health centre in the last 12 months

E3. Did someone explain the results of the tests in a way you could understand?

	National average %	Number
Yes, definitely	68	
Yes, to some extent	23	
No	9	
Total specific responses		58943
Missing responses		2729
I am still waiting for the results		3340
Not sure/can't remember		769

Answered by those who had had a test carried out by someone from their health centre in the last 12 months

F. Referrals

F1. In the last 12 months, has anyone at your surgery referred you to a specialist (for example a hospital consultant)?

	National average %	Number
Yes	36	
No	64	
Total specific responses		120012
Missing responses		2101

Answered by all

F2. Were you given a choice about where you were referred (ie, which hospital)?

	National average %	Number
Yes	26	
No, but I would have liked a choice	16	
No, but I did not mind	58	
Total specific responses		42614
Missing responses		2309
Don't know/can't remember		300

Answered by those who had been referred to a specialist within the last 12 months

F3. When you first saw the person you were referred to, did he/she seem to have all the necessary information?

	National average %	Number
Yes, completely	63	
Yes, to some extent	29	
No	8	
Total specific responses		38645
Missing responses		2558
I have not been yet		3563
Don't know/can't remember		457

Answered by those who had been referred to a specialist within the last 12 months

G. Seeing another professional from a health centre

G1. Have you seen anyone else from a health centre other than a doctor in the last 12 months?

	National average %	Number
Yes	49	
No	51	
Total specific responses		119723
Missing responses		2390

Answered by all

G2. The last time you saw someone other than a doctor from a GP surgery or health centre, who did you see?

	National average %	Number
A practice nurse or nurse practitioner	79	
A midwife	3	
A district nurse	5	
A health visitor	3	
Someone else	10	
I was not sure who I saw	0	
Total specific responses		58592
Missing responses		2989

Answered by those who had seen someone from a health centre other than a doctor in the last 12 months

G3. Were you involved as much as you wanted to be in decisions about your care and treatment?

	National average %	Number
Yes, definitely	79	
Yes, to some extent	18	
No	3	
Total specific responses		54560
Missing responses		2317
No decisions had to be made		4704

Answered by those who had seen someone from a health centre other than a doctor in the last 12 months

G4. Did that person explain the reasons for any treatment or action in a way that you could understand?

	National average %	Number
Yes, completely	82	
Yes, to some extent	16	
No	3	
Total specific responses		52609
Missing responses		2457
G4_4rem		4089
No treatment or action was required		2426

Answered by those who had seen someone from a health centre other than a doctor in the last 12 months

G5. Did you have confidence and trust in that person?

	National average %	Number
Yes, definitely	81	
Yes, to some extent	17	
No	2	
Total specific responses		59040
Missing responses		2541

Answered by those who had seen someone from a health centre other than a doctor in the last 12 months

G6. Did that person treat you with respect and dignity?

	National average %	Number
Yes, all of the time	94	
Yes, some of the time	5	
No	1	
Total specific responses		58830
Missing responses		2751

Answered by those who had seen someone from a health centre other than a doctor in the last 12 months

Overall about your GP surgery/health centre

H1. In your opinion, how clean is the surgery/health centre?

	National average %	Number
Very clean	73	
Fairly clean	25	
Not very clean	1	
Not at all clean	0	
Total specific responses		117505
Can't say		3188
Missing responses		1420

Answered by all

H2. In the last 12 months, have you been put off going to your GP surgery because opening times are inconvenient for you?

	National average %	Number
Yes, often	6	
Yes, sometimes	16	
No	78	
Total specific responses		119544
Missing responses		2569

Answered by all

J. Dental care

J1. Are you currently registered with a dentist as an NHS patient?

	National average %	Number
Yes	58	
No, but registered with dentist as non-NHS patient	21	
No, I am not registered with any dentist at all	20	
Total specific responses		116263
Missing responses		2526
Don't know		3324

Answered by all

J2. Would you like to be registered with a dentist as an NHS patient?

	National average %	Number
Yes	67	
No	33	
Total specific responses		49810
Missing responses		4514

Answered by those not currently registered with a dentist as an NHS patient

J3. In the last 12 months, have you visited a dentist as an NHS patient?

	National average %	Number
Yes	52	
No	48	
Total specific responses		117712
Missing responses		3183
Not sure/can't remember		1218

Answered by all

J4. Were you involved as much as you wanted to be in decisions about your dental care and treatment?

	National average %	Number
Yes, definitely	69	
Yes, to some extent	25	
No	6	
Total specific responses		61996
Missing responses		3337

Answered by those who had visited a dentist as an NHS patient in the last 12 months

J5. Did the dentist explain the reasons for any treatment or action in a way that you could understand?

	National average %	Number
Yes, completely	77	
Yes, to some extent	20	
No	3	
Total specific responses		55112
Missing responses		3350
I did not need an explanation		1798
No treatment or action was needed		5073

Answered by those who had visited a dentist as an NHS patient in the last 12 months

J6. Did dental staff do everything they could to help control any pain you experienced?

	National average %	Number
Yes, definitely	77	
Yes, to some extent	19	
No	4	
Total specific responses		38802
Missing responses		3856
Can't say/don't know		577
I did not experience any pain		22098

Answered by those who had visited a dentist as an NHS patient in the last 12 months

J7. Did you have confidence and trust in the dentist?

	National average %	Number
Yes, completely	75	
Yes, to some extent	22	
No	3	
Total specific responses		62020
Missing responses		3313

Answered by those who had visited a dentist as an NHS patient in the last 12 months

K. Health promotion

K1. Have you ever smoked a cigarette, a cigar or a pipe?

	National average %	Number
Yes	56	
No	44	
Total specific responses		118736
Missing responses		3377

Answered by all

K2. Do you smoke cigarettes at all nowadays?

	National average %	Number
Yes	35	
No	65	
Total specific responses		66304
Missing responses		3604

Answered by all those who had ever smoked a cigarette, a cigar, or a pipe

K3. In the last 12 months, have you been given advice or help from your GP surgery/health centre on giving up smoking?

	National average %	Number
Yes, definitely	19	
Yes, to some extent	16	
No, but I would have liked help/advice	19	
No, but I did not want any help/advice	46	
Total specific responses		23518
Missing responses		2702

Answered by those who smoke cigarettes nowadays

K4. In the last 12 months have you had your blood pressure taken by anyone from your GP surgery/ health centre?

	National average %	Number
Yes	64	
No	36	
Total specific responses		116156
Missing responses		1979
Not sure/can't remember		3978

Answered by all

K5. In the last 12 months, have you been offered a flu jab (influenza vaccination)?

	National average %	Number
Yes, and I have had a flu jab in the last 12 months	84	
I have been offered it but have not had a flu jab in last 12 months	14	
No, not been offered a flu jab in the last 12 months	2	
Total specific responses		30634
Missing responses		998
I do not think I need a flu jab		1318
Not sure/can't remember		1246

Answered by all, but data above refers only to patients aged 65 or over

L. About you

L1. Are you male or female?

	National average %	Number
Male	41	
Female	59	
Total specific responses		120033
Missing responses		2080

Answered by all

Age (From L2: What was your year of birth?)

	Percentage	Total
16-35	20	
36-50	25	
51-65	28	
66-80	21	
81 or over	6	
Base excluding missing responses (n)		116359
Missing responses (n)		5754

Answered by all

L3. How old were you when you left full time education?

	National average %	Number
16 years or less	59	
17 or 18 years	20	
19 years or over	18	
Still in full time education	4	
Total specific responses		118702
Missing responses		3411

Answered by all

L4. Overall, how would you rate your health during the past four weeks?

	National average %	Total
Excellent	13	
Very good	26	
Good	30	
Fair	22	
Poor	7	
Very poor	2	
Total specific responses		119887
Missing responses		2226

Answered by all

L5. To which of these ethnic groups would you say you belong?

	National average %	Number
White	94	
Asian or Asian British	3	
Black or Black British	2	
Chinese, Mixed, or Other Ethnic Group	1	
Total specific responses		119158
Missing responses		2955

Answered by all

Response rates for demographic groups

Adjusted response rates by SEX

		Adjusted response rate %	Base
Sex	Male	43	121742
	Female	55	127784
	Missing	75	12
Total		49	249538

Adjusted response rates by AGE GROUP

		Adjusted response rate %	Base
Age	16-35	32	80986
	36-50	45	67713
	51-65	63	54274
	66-80	71	34830
	81 or over	54	11725
	missing	90	10
Total		49	249538

Adjusted response rate by AGE GROUP and SEX

			Adjusted response rate %	
Female		16-35	41	40335
		36-50	54	33675
		51-65	69	27067
		66-80	71	18801
		81 or over	50	7906
	Total		55	127784
Male		16-35	24	40648
		36-50	37	34037
		51-65	57	27207
		66-80	71	16029
		81 or over	61	3819
	Total		43	121740

Crosstabulations comparing different kinds of "other health professional"

NB Tables in this section are based on all responses, not on trust-based means.

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

		Were you involved as much as you wanted to be in decisions about your care and treatment?			
		Yes, definitely	Yes, to some extent	No	Base (n)
The last time you saw someone other than a doctor from a GP surgery or health centre, who did you see?	A practice nurse or nurse practitioner	82%	16%	2%	42763
	A midwife	76%	20%	4%	1419
	A district nurse	76%	19%	4%	2533
	A health visitor	72%	24%	4%	1540

Did you have confidence and trust in that person?

		Did you have confidence and trust in that person?			
		Yes, definitely	Yes, to some extent	No	Base (n)
The last time you saw someone other than a doctor from a GP surgery or health centre, who did you see?	A practice nurse or nurse practitione	84%	15%	2%	46344
	A midwife	76%	20%	4%	1445
	A district nurse	82%	16%	1%	2694
	A health visitor	67%	28%	6%	1744

Did that person explain the reasons for any treatment or action in a way that you could understand?

		Did that person explain the reasons for any treatment or action in a way that you could understand?			
		Yes, completely	Yes, to some extent	No	Base (n)
The last time you saw someone other than a doctor from a GP surgery or health centre, who did you see?	A practice nurse or nurse practitioner	84%	14%	2%	41116
	A midwife	78%	19%	3%	1371
	A district nurse	80%	17%	3%	2464
	A health visitor	75%	22%	3%	1422

Did that person treat you with respect and dignity?

		Did that person treat you with respect and dignity?			
		Yes, all of the time	Yes, some of the time	No	Base (n)
The last time you saw someone other than a doctor from a GP surgery or health centre, who did you see?	A practice nurse or nurse practitioner	95%	4%	1%	46166
	A midwife	90%	8%	2%	1438
	A district nurse	94%	5%	1%	2673
	A health visitor	87%	11%	2%	1730

Tables of differences between comparable items in the 2003 and 2004 local health services surveys using trust based national averages

Note: All figures are rounded to whole numbers which may account for apparent inconsistencies between the columns showing results for each year, and the difference column

A2. The last time you saw a doctor from your GP surgery did you have to wait for an appointment?

	2003	2004	difference
No, I was seen without an appointment	9%	7%	-3%
I was seen on the same working day	16%	29%	12%
I had to wait 1 or 2 working days	15%	25%	9%
I had to wait more than 2 working days	22%	23%	1%
It was a pre-planned appointment or visit	35%	17%	-19%
Base excluding missing responses	89755	100316	

Answered by those who had made an appointment with a GP in the last 12 months.

B5 Did someone tell you how long you would have to wait?

	2003	2004	difference
Yes	11%	8%	-3%
No, but I would have liked to have been told	51%	43%	-11%
No, but I did not mind	34%	49%	14%
Base excluding missing responses	34216	80110	

Answered by all who had visited surgery in last 12 months and who either did not have an appointment or were not seen on time.

C3. Were you given enough time to discuss your health or medical problem with the doctor?

	2003	2004	difference
Yes, definitely	75%	74%	-4%
Yes, to some extent	20%	22%	3%
No	3%	4%	1%
Base excluding missing responses	91111	101930	

Answered by all who had seen a doctor from their GP surgery or health centre in last 12 months.

C4 Were you involved as much as you wanted to be in decisions about your care and treatment?

	2003	2004	difference
Yes, definitely	73%	69%	-5%
Yes, to some extent	22%	27%	5%
No	5%	5%	0%
Base excluding missing responses	90340	102383	

Answered by all who had seen a doctor from their GP surgery or health centre in last 12 months.

D2. Were you involved as much as you wanted to be in decisions about the best medicine for you?

	2003	2004	difference
Yes, definitely	55%	59%	4%
Yes, to some extent	30%	29%	-1%
No	15%	12%	-3%
Base excluding missing responses	55041	62998	

Answered by patients who had been prescribed new medicines by their doctor/nurse practitioner in the last 12 months.

E3 Did someone explain the results of the tests in a way you could understand?

	2003	2004	difference
Yes, definitely	72%	68%	-4%
Yes, to some extent	21%	23%	2%
No	6%	9%	5%
Base excluding missing responses	49842	62283	

Answered by all those who had had a test carried out by someone from their health centre in the last 12 months.

G4. Did that person explain the reasons for any action or treatment in a way that you could understand? (Health professional other than GP)

	2003	2004	difference
Yes, completely	82%	82%	0%
Yes, to some extent	16%	16%	0%
No	3%	3%	0%
Base excluding missing responses (n)	11885	52609	

Answered by patients who had seen a healthcare professional other than a doctor from their health centre in the last 12 months

H2. In the last 12 months, have you ever been put off going to your GP surgery/health centre because the opening times are inconvenient for you?

	2003	2004	difference
Yes, often	6%	6%	0%
Yes, sometimes	14%	16%	2%
No	80%	78%	-2%
Base excluding missing responses	121511	119544	

Answered by all.

J4. Were you involved as much as you wanted to be in decisions about your dental care and treatment?

	2003	2004	difference
Yes, definitely	75%	69%	-6%
Yes, to some extent	20%	25%	5%
No	5%	6%	1%
Base excluding missing responses	61939	61996	

Answered by those who had visited a dentist as an NHS patient within the last 12 months.

J7. Did you have confidence and trust in the dentist?

	2003	2004	difference
Yes, completely	77%	75%	-2%
Yes, to some extent	20%	22%	2%
No	3%	3%	1%
Base excluding missing responses	62787	62020	

Answered by those who had visited a dentist as an NHS patient within the last 12 months.

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