INPATIENT QUESTIONNAIRE

What is the survey about?

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

Who should complete the questionnaire?

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

Completing the questionnaire

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

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

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

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

Questions or help?

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

Taking part in this survey is voluntary.
Your answers will be treated in confidence.

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

ADMISSION TO HOSPITAL

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

1 ☐ Emergency or urgent ➔ **Go to 2**

2 ☐ Waiting list or planned in advance ➔ **Go to 6**

3 ☐ Something else ➔ **Go to 2**

THE ACCIDENT & EMERGENCY DEPARTMENT

2. When you arrived at the hospital, did you go to the A&E Department (the Emergency Department / Casualty / Medical or Surgical Admissions unit)?

1 ☐ Yes ➔ **Go to 3**

2 ☐ No ➔ **Go to 6**

3. While you were in the A&E Department, how much information about your condition or treatment was given to you?

50 1 ☐ Not enough

100 2 ☐ Right amount

50 3 ☐ Too much

0 4 ☐ I was not given any information about my treatment or condition

- 5 ☐ Don't know / Can't remember

4. Were you given enough privacy when being examined or treated in the A&E Department?

100 1 ☐ Yes, definitely

50 2 ☐ Yes, to some extent

0 3 ☐ No

- 4 ☐ Don't know / Can't remember

5. Following arrival at the hospital, how long did you wait before being admitted to a bed on a ward?

100 1 ☐ Less than 1 hour

75 2 ☐ At least 1 hour but less than 2 hours

50 3 ☐ At least 2 hours but less than 4 hours

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

0 5 ☐ 8 hours or longer

- 6 ☐ Can't remember

100 7 ☐ I did not have to wait

EMERGENCY & URGENTLY ADMITTED PATIENTS, now please go to Question 12

WAITING LIST & PLANNED ADMISSION PATIENTS, please continue to Question 6

WAITING LIST OR PLANNED ADMISSION

6. When you were referred to see a specialist, were you offered a choice of hospital for your **first hospital appointment**?

$_1$ ☐ Yes

$_2$ ☐ No, but I would have liked a choice

$_3$ ☐ No, but I did not mind

$_4$ ☐ Don't know / Can't remember

7. Who referred you to see a specialist?

$_1$ ☐ A doctor from my local general practice

$_2$ ☐ Any other doctor or specialist

$_3$ ☐ A practice nurse or nurse practitioner

$_4$ ☐ Any other health professional (for example, a dentist, optometrist or physiotherapist)

$_5$ ☐ Don't know / Can't remember

Thinking about the person who referred you to hospital…

8. Overall, from the time you first talked to this health professional about being referred to a hospital, how long did you wait to be admitted to hospital?

100$_1$ ☐ Up to 1 month

75$_2$ ☐ 1 to 2 months

50$_3$ ☐ 3 to 4 months

25$_4$ ☐ 5 to 6 months

0$_5$ ☐ More than 6 months

- $_6$ ☐ Don't know / Can't remember

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

100$_1$ ☐ I was admitted as soon as I thought was necessary

50$_2$ ☐ I should have been admitted a bit sooner

0$_3$ ☐ I should have been admitted a lot sooner

10. Were you given a choice of **admission dates**?

100$_1$ ☐ Yes

0$_2$ ☐ No

- $_3$ ☐ Don't know / Can't remember

11. Was your admission date changed by the hospital?

100$_1$ ☐ No

67$_2$ ☐ Yes, once

33$_3$ ☐ Yes, 2 or 3 times

0$_4$ ☐ Yes, 4 times or more

ALL TYPES OF ADMISSION

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

0$_1$ ☐ Yes, definitely

50$_2$ ☐ Yes, to some extent

100$_3$ ☐ No

THE HOSPITAL AND WARD

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

1 ☐ Yes

2 ☐ No

3 ☐ Don't know / Can't remember

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

0 1 ☐ Yes ➔ **Go to 15**

100 2 ☐ No ➔ **Go to 16**

15. When you were **first** admitted, did you mind sharing a sleeping area, for example a room or bay, with patients of the opposite sex?

1 ☐ Yes

2 ☐ No

Q14 and Q17 are scored together to provide a single score on whether patients who have not stayed in a critical care area have ever shared a sleeping area with members of the opposite sex.

Q14 and Q17 are not scored if option 1 ("Yes") is selected to Q13.

Q14 and Q17 score "100" if the respondent did not ever share a sleeping area with patients of the opposite sex, i.e. selected option 2 ("No") to Q14 AND option 2 ("No") to Q17.

If option 1 ("Yes") is selected for EITHER Q14 or Q17 then a score of "0" is assigned.

If ONE of Q14 & Q17 is missing, the other is used for scoring.

Q15 and Q18 are not scored.

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

1 ☐ 1 ➔ **Go to 19**

2 ☐ 2 ➔ **Go to 17**

3 ☐ 3 or more ➔ **Go to 17**

4 ☐ Don't know / Can't remember ➔ **Go to 19**

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

0 1 ☐ Yes ➔ **Go to 18**

100 2 ☐ No ➔ **Go to 19**

18. **After you moved**, did you mind sharing a sleeping area, for example a room or bay, with patients of the opposite sex?

1 ☐ Yes

2 ☐ No

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

0 1 ☐ Yes

100 2 ☐ Yes, because it had special bathing equipment that I needed

100 3 ☐ No

- 4 ☐ I did not use a bathroom or shower

- 5 ☐ Don't know / Can't remember

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

0 1 ☐ Yes

100 2 ☐ No

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

0$_1$ ☐ Yes

100$_2$ ☐ No

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

100$_1$ ☐ Very clean

67$_2$ ☐ Fairly clean

33$_3$ ☐ Not very clean

0$_4$ ☐ Not at all clean

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

100$_1$ ☐ Very clean

67$_2$ ☐ Fairly clean

33$_3$ ☐ Not very clean

0$_4$ ☐ Not at all clean

- $_5$ ☐ I did not use a toilet or bathroom

24. Did you feel threatened during your stay in hospital by other patients or visitors?

0$_1$ ☐ Yes

100$_2$ ☐ No

25. Did you have somewhere to keep your personal belongings whilst on the ward?

100$_1$ ☐ Yes, and I could lock it if I wanted to

50$_2$ ☐ Yes, but I could not lock it

0$_3$ ☐ No

- $_4$ ☐ I did not take any belongings to hospital

- $_5$ ☐ Don't know / Can't remember

26. Did you see any posters or leaflets on the ward asking patients and visitors to wash their hands or to use hand-wash gels?

100$_1$ ☐ Yes

0$_2$ ☐ No

- $_3$ ☐ Can't remember

27. Were hand-wash gels available for patients and visitors to use?

100$_1$ ☐ Yes

0$_2$ ☐ Yes, but they were empty

0$_3$ ☐ I did not see any hand-wash gels

- $_4$ ☐ Don't know / Can't remember

28. How would you rate the hospital food?

Deleted: ¶

100$_1$ ☐ Very good

67$_2$ ☐ Good

33$_3$ ☐ Fair

0$_4$ ☐ Poor

- $_5$ ☐ I did not have any hospital food

29. Were you offered a choice of food?

100$_1$ ☐ Yes, always

50$_2$ ☐ Yes, sometimes

0$_3$ ☐ No

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

100$_1$ ☐ Yes, always

50$_2$ ☐ Yes, sometimes

0$_3$ ☐ No

- $_4$ ☐ I did not need help to eat meals

DOCTORS

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

100₁ ☐ Yes, always

50₂ ☐ Yes, sometimes

0₃ ☐ No

- ₄ ☐ I had no need to ask

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

100₁ ☐ Yes, always

50₂ ☐ Yes, sometimes

0₃ ☐ No

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

0₁ ☐ Yes, often

50₂ ☐ Yes, sometimes

100₃ ☐ No

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

100₁ ☐ Yes, always

50₂ ☐ Yes, sometimes

0₃ ☐ No

- ₄ ☐ Don't know / Can't remember

NURSES

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

100₁ ☐ Yes, always

50₂ ☐ Yes, sometimes

0₃ ☐ No

- ₄ ☐ I had no need to ask

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

100₁ ☐ Yes, always

50₂ ☐ Yes, sometimes

0₃ ☐ No

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

0₁ ☐ Yes, often

50₂ ☐ Yes, sometimes

100₃ ☐ No

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

100₁ ☐ There were always or nearly always enough nurses

50₂ ☐ There were sometimes enough nurses

0₃ ☐ There were rarely or never enough nurses

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

100₁ ☐ Yes, always

50₂ ☐ Yes, sometimes

0₃ ☐ No

- ₄ ☐ Don't know / Can't remember

YOUR CARE AND TREATMENT

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

0₁ ☐ Yes, often

50₂ ☐ Yes, sometimes

100₃ ☐ No

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

100₁ ☐ Yes, definitely

50₂ ☐ Yes, to some extent

0₃ ☐ No

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

0₁ ☐ Not enough

100₂ ☐ The right amount

0₃ ☐ Too much

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

100₁ ☐ Yes, definitely

50₂ ☐ Yes, to some extent

0₃ ☐ No

- ₄ ☐ No family or friends were involved

- ₅ ☐ My family did not want or need information

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

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

100₁ ☐ Yes, definitely

50₂ ☐ Yes, to some extent

0₃ ☐ No

- ₄ ☐ I had no worries or fears

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

100₁ ☐ Yes, always

50₂ ☐ Yes, sometimes

0₃ ☐ No

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

100₁ ☐ Yes, always

50₂ ☐ Yes, sometimes

0₃ ☐ No

47. Were you ever in any pain?

1 ☐ Yes ➔ **Go to 48**

2 ☐ No ➔ **Go to 49**

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

100 1 ☐ Yes, definitely

50 2 ☐ Yes, to some extent

0 3 ☐ No

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

100 1 ☐ 0 minutes/right away

75 2 ☐ 1-2 minutes

50 3 ☐ 3-5 minutes

25 4 ☐ More than 5 minutes

0 5 ☐ I never got help when I used the call button

- 6 ☐ I never used the call button

OPERATIONS & PROCEDURES

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

1 ☐ Yes ➔ **Go to 51**

2 ☐ No ➔ **Go to 58**

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

100 1 ☐ Yes, completely

50 2 ☐ Yes, to some extent

0 3 ☐ No

- 4 ☐ I did not want an explanation

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

100 1 ☐ Yes, completely

50 2 ☐ Yes, to some extent

0 3 ☐ No

- 4 ☐ I did not want an explanation

53. Beforehand, did a member of staff answer your questions about the operation or procedure in a way you could understand?

100 1 ☐ Yes, completely

50 2 ☐ Yes, to some extent

0 3 ☐ No

- 4 ☐ I did not have any questions

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

100₁ ☐ Yes, completely

50₂ ☐ Yes, to some extent

0₃ ☐ No

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

₁ ☐ Yes **➔ Go to 56**

₂ ☐ No **➔ Go to 57**

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

100₁ ☐ Yes, completely

50₂ ☐ Yes, to some extent

0₃ ☐ No

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

100₁ ☐ Yes, completely

50₂ ☐ Yes, to some extent

0₃ ☐ No

LEAVING HOSPITAL

58. Did you feel you were involved in decisions about your discharge from hospital?

100₁ ☐ Yes, definitely

50₂ ☐ Yes, to some extent

0₃ ☐ No

- ₄ ☐ I did not need to be involved

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

0₁ ☐ Yes **➔ Go to 60**

100₂ ☐ No **➔ Go to 62**

Q59 is used to score Q60 and Q61. See scoring notes under Q60 and Q61 for details.

60. What was the **MAIN** reason for the delay? (**Tick ONE only**)

0₁ ☐ I had to wait for **medicines**

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

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

- ₄ ☐ Something else

If response to Q59 is 2 (discharge WAS NOT delayed), Q60 is scored 100.

If response to Q59 is 1 (discharge WAS delayed), and response to Q60 is 1, 2, 3 or 4, the scores above are assigned to Q60. If Q59 is missing, Q60 is not scored. If Q60 is missing, scoring is as per Q59.

61. How long was the delay?

75₁ ☐ Up to 1 hour

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

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

0₄ ☐ Longer than 4 hours

If response to Q60 is 4 (some other reason for the delay), Q61 is not scored.
If response to Q59 is 2 (discharge WAS NOT delayed), Q61 is scored 100.
If response to Q59 is 1 (discharge WAS delayed) AND the response to Q60 is 1, 2 or 3, the scores above are assigned to Q61.
If response to Q59 is 1 (discharge WAS delayed) AND the response to Q60 is missing, the scores above are assigned to Q61.
If response to Q59 is 1 (discharge WAS delayed) AND the response to Q61 is missing, Q61 is not scored.
If response to Q59 is missing, Q61 is not scored

62. Before you left hospital, were you given any written or printed information about what you should or should not do after leaving hospital?

100₁ ☐ Yes

0₂ ☐ No

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

100₁ ☐ Yes, completely **➔ Go to 64**

50₂ ☐ Yes, to some extent **➔ Go to 64**

0₃ ☐ No **➔ Go to 64**

- ₄ ☐ I did not need an explanation **➔ Go to 64**

- ₅ ☐ I had no medicines **➔ Go to 67**

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

100₁ ☐ Yes, completely

50₂ ☐ Yes, to some extent

0₃ ☐ No

- ₄ ☐ I did not need an explanation

65. Were you told how to **take** your medication in a way you could understand?

100₁ ☐ Yes, definitely

50₂ ☐ Yes, to some extent

0₃ ☐ No

- ₄ ☐ I did not need to be told how to take my medication

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

100₁ ☐ Yes, completely

50₂ ☐ Yes, to some extent

0₃ ☐ No

- ₄ ☐ Don't know / Can't remember

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

100₁ ☐ Yes, completely

50₂ ☐ Yes, to some extent

0₃ ☐ No

- ₄ ☐ It was not necessary

68. Did the doctors or nurses give your family or someone close to you all the information they needed to help care for you?

100₁ ☐ Yes, definitely

50₂ ☐ Yes, to some extent

0₃ ☐ No

- ₄ ☐ No family or friends were involved

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

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

100₁ ☐ Yes

0₂ ☐ No

- ₃ ☐ Don't know / Can't remember

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

100₁ ☐ Yes, I received copies **➔ Go to 71**

0₂ ☐ No, I did not receive copies **➔ Go to** Error! Reference source not found.

- ₃ ☐ Not sure / Don't know **➔ Go to** Error! Reference source not found.

71. Were the letters written in a way that you could understand?

100₁ ☐ Yes, definitely

50₂ ☐ Yes, to some extent

0₃ ☐ No

- ₄ ☐ Not sure / Don't know

OVERALL

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

100₁ ☐ Yes, always

50₂ ☐ Yes, sometimes

0₃ ☐ No

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

100₁ ☐ Excellent

75₂ ☐ Very good

50₃ ☐ Good

25₄ ☐ Fair

0₅ ☐ Poor

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

100₁ ☐ Excellent

75₂ ☐ Very good

50₃ ☐ Good

25₄ ☐ Fair

0₅ ☐ Poor

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

100₁ ☐ Yes

0₂ ☐ No

- ₃ ☐ Don't know / Can't remember

76. While in hospital, did you ever see any posters or leaflets explaining how to complain about the care you received?

100₁ ☐ Yes

0₂ ☐ No

- ₃ ☐ Don't know / Can't remember

77. Did you want to complain about the care you received in hospital?

0$_1$ ☐ Yes

100$_3$ ☐ No

ABOUT YOU

78. Are you male or female?

1 ☐ Male

2 ☐ Female

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

(Please write in) e.g.

1	9	3	4

1	**9**	Y	Y

Your own health state today

By placing a tick in one box in each group below, please indicate which statements best describe your own health state **today**.

80. Mobility

1 ☐ I have no problems in walking about

2 ☐ I have some problems in walking about

3 ☐ I am confined to bed

81. Self-Care

1 ☐ I have no problems with self-care

2 ☐ I have some problems washing or dressing myself

3 ☐ I am unable to wash or dress myself

82. Usual Activities (e.g. work, study, housework, family or leisure activities)

1 ☐ I have no problems with performing my usual activities

2 ☐ I have some problems with performing my usual activities

3 ☐ I am unable to perform my usual activities

83. Pain / Discomfort

1 ☐ I have no pain or discomfort

2 ☐ I have moderate pain or discomfort

3 ☐ I have extreme pain or discomfort

84. Anxiety / Depression

1 ☐ I am not anxious or depressed

2 ☐ I am moderately anxious or depressed

3 ☐ I am extremely anxious or depressed

85. Do you have any of the following long-standing conditions? **(Tick ALL that apply)**

1 ☐ Deafness or severe hearing impairment **➔ Go to 86**

2 ☐ Blindness or partially sighted **➔ Go to 86**

3 ☐ A long-standing physical condition **➔ Go to 86**

4 ☐ A learning disability **➔ Go to 86**

5 ☐ A mental health condition **➔ Go to 86**

6 ☐ A long-standing illness, such as cancer, HIV, diabetes, chronic heart disease, or epilepsy **➔ Go to 86**

7 ☐ No, I do not have a long-standing condition **➔ Go to 87**

86. Does this condition(s) cause you difficulty with any of the following? **(Tick ALL that apply)**

1 ☐ Everyday activities that people your age can usually do

2 ☐ At work, in education, or training

3 ☐ Access to buildings, streets, or vehicles

4 ☐ Reading or writing

5 ☐ People's attitudes to you because of your condition

6 ☐ Communicating, mixing with others, or socialising

7 ☐ Any other activity

8 ☐ No difficulty with any of these

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

a. WHITE

1 ☐ British

2 ☐ Irish

3 ☐ Any other white background **(Please write in box)**

b. MIXED

4 ☐ White and Black Caribbean

5 ☐ White and Black African

6 ☐ White and Asian

7 ☐ Any other mixed background **(Please write in box)**

c. ASIAN OR ASIAN BRITISH

8 ☐ Indian

9 ☐ Pakistani

10 ☐ Bangladeshi

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

d. BLACK OR BLACK BRITISH

12 ☐ Caribbean

13 ☐ African

14 ☐ Any other black background **(Please write in box)**

e. CHINESE OR OTHER ETHNIC GROUP

15 ☐ Chinese

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

OTHER COMMENTS

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

Was there anything particularly good about your hospital care?

Was there anything that could be improved?

Any other comments?

THANK YOU VERY MUCH FOR YOUR HELP

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

Please post this questionnaire back in the FREEPOST envelope provided.

No stamp is needed.

Non survey variable definitions: 2009 Inpatients Survey Data

Variable name	Description	Values
Trustcode	Department of Health Trust code	(please see IP09 trust list.xls for the name of trusts)
LOS	Length of stay (in days)	-
DisSpec	Speciality on discharge	-
MainSpec	Main speciality	-
outcome	Outcome of sending questionnaire	Returned useable questionnaire=**1** Returned undelivered=**2** Service user died , opted out or returned blank questionnaire=**4** Service user was not eligible to fill in questionnaire=**5** Questionnaire not returned - reason not known=**6**
age_group	age grouped. Based on respondent provided information, or where missing, this information was taken from the sample file.	16-35=**1** 36-50=**2** 51-65=**3** 66+=**4**
all_gender	Based on respondent provided information, or where missing, this information was taken from the sample file.	male=**1** female=**2**

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	

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[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	Trusts

- What proportion of patients nationally felt that the toilets and bathrooms were not very or not at all clean?
- Were males or females more likely to say that toilets and bathrooms were not very or not at all clean?

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

Calculating patient population weights

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

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

where:

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

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

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

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

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

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

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

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

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

Patten Smith
4 November 2005

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

Trust code	Trust name
5QT	Isle of Wight NHS Primary Care Trust
RA2	Royal Surrey County Hospital NHS Trust
RA3	Weston Area Health NHS Trust
RA4	Yeovil District Hospital NHS Foundation Trust
RA7	University Hospitals Bristol NHS Foundation Trust
RA9	South Devon Healthcare NHS Foundation Trust
RAE	Bradford Teaching Hospitals NHS Foundation Trust
RAJ	Southend University Hospital NHS Foundation Trust
RAL	Royal Free Hampstead NHS Trust
RAN	Royal National Orthopaedic Hospital NHS Trust
RAP	North Middlesex University Hospital NHS Trust
RAS	The Hillingdon Hospital NHS Trust
RAX	Kingston Hospital NHS Trust
RBA	Taunton and Somerset NHS Trust
RBB	Royal National Hospital for Rheumatic Diseases NHS Foundation Trust
RBD	Dorset County Hospital NHS Foundation Trust
RBF	Nuffield Orthopaedic Centre NHS Trust
RBK	Walsall Hospitals NHS Trust
RBL	Wirral Hospital NHS Trust
RBN	St Helens and Knowsley Hospitals NHS Trust
RBQ	Liverpool Heart & Chest Hospital NHS Trust
RBT	The Mid Cheshire Hospitals NHS Trust
RBV	Christie Hospital NHS Trust
RBZ	Northern Devon Healthcare NHS Trust
RC1	Bedford Hospital NHS Trust
RC3	Ealing Hospital NHS Trust
RC9	Luton and Dunstable Hospital NHS Foundation Trust
RCB	York Hospitals NHS Trust
RCC	Scarborough and North East Yorkshire Health Care NHS Trust
RCD	Harrogate and District NHS Foundation Trust
RCF	Airedale NHS Trust
RCX	The Queen Elizabeth Hospital King's Lynn NHS Trust
RD1	Royal United Hospital Bath NHS Trust
RD3	Poole Hospital NHS Trust
RD7	Heatherwood and Wexham Park Hospitals NHS Trust
RD8	Milton Keynes General Hospital NHS Trust
RDD	Basildon and Thurrock University Hospitals NHS Foundation Trust
RDE	Colchester Hospital University NHS Foundation Trust
RDU	Frimley Park Hospital NHS Foundation Trust
RDZ	Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust
RE9	South Tyneside NHS Foundation Trust
REF	Royal Cornwall Hospitals NHS Trust
REM	Aintree University Hospitals NHS Foundation Trust
REN	Clatterbridge Centre for Oncology NHS Foundation Trust
REP	Liverpool Womens Hospital NHS Foundation Trust
RET	Walton Centre for Neurology and Neurosurgery NHS Trust
RF4	Barking, Havering and Redbridge Univeristy Hospitals NHS Trust
RFF	Barnsley Hospital NHS Foundation Trust
RFR	The Rotherham NHS Foundation Trust
RFS	Chesterfield Royal Hospital NHS Foundation Trust
RFW	West Middlesex University Hospital NHS Trust
RGC	Whipps Cross University Hospital NHS Trust
RGM	Papworth Hospital NHS Foundation Trust
RGN	Peterborough and Stamford Hospitals NHS Foundation Trust
RGP	James Paget University Hospitals NHS Foundation Trust
RGQ	Ipswich Hospital NHS Trust
RGR	West Suffolk Hospitals NHS Trust
RGT	Cambridge University Hospitals NHS Foundation Trust

RH8	Royal Devon and Exeter NHS Foundation Trust
RHM	Southampton University Hospitals NHS Trust
RHQ	Sheffield Teaching Hospitals NHS Foundation Trust
RHU	Portsmouth Hospitals NHS Trust
RHW	Royal Berkshire NHS Foundation Trust
RJ1	Guy's and St Thomas' NHS Foundation Trust
RJ2	The Lewisham Hospital NHS Trust
RJ6	Mayday Healthcare NHS Trust
RJ7	St George's Healthcare NHS Trust
RJC	South Warwickshire General Hospitals NHS Trust
RJD	Mid Staffordshire NHS Foundation Trust
RJE	University Hospital Of North Staffordshire NHS Trust
RJF	Burton Hospitals NHS Foundation Trust
RJL	Northern Lincolnshire and Goole Hospitals NHS Foundation Trust
RJN	East Cheshire NHS Trust
RJR	Countess Of Chester Hospital NHS Foundation Trust
RJZ	King's College Hospital NHS Foundation Trust
RK5	Sherwood Forest Hospitals NHS Foundation Trust
RK9	Plymouth Hospitals NHS Trust
RKB	University Hospitals Coventry and Warwickshire NHS Trust
RKE	The Whittington Hospital NHS Trust
RL1	Robert Jones and Agnes Hunt Orthopaedic and District Hospital NHS Trust
RL4	The Royal Wolverhampton Hospitals NHS Trust
RLN	City Hospitals Sunderland NHS Foundation Trust
RLQ	Hereford Hospitals NHS Trust
RLT	George Eliot Hospital NHS Trust
RLU	Birmingham Women's NHS Foundation Trust
RM1	Norfolk and Norwich University Hospital NHS Trust
RM2	University Hospital of South Manchester NHS Foundation Trust
RM3	Salford Royal NHS Foundation Trust
RM4	Trafford Healthcare NHS Trust
RMC	Royal Bolton Hospital NHS Foundation Trust
RMP	Tameside Hospital NHS Foundation Trust
RN1	Winchester and Eastleigh Healthcare NHS Trust
RN3	Great Western Hospitals NHS Foundation Trust
RN5	Basingstoke and North Hampshire NHS Foundation Trust
RN7	Dartford and Gravesham NHS Trust
RNA	The Dudley Group of Hospitals NHS Foundation Trust
RNH	Newham University Hospital NHS Trust
RNJ	Barts and The London NHS Trust
RNL	North Cumbria University Hospitals NHS Trust
RNQ	Kettering General Hospital NHS Foundation Trust
RNS	Northampton General Hospital NHS Trust
RNZ	Salisbury NHS Foundation Trust
RP5	Doncaster and Bassetlaw Hospitals NHS Foundation Trust
RPA	Medway NHS Trust
RPC	Queen Victoria Hospital NHS Foundation Trust
RPY	The Royal Marsden NHS Foundation Trust
RQ6	Royal Liverpool and Broadgreen University Hospitals NHS Trust
RQ8	Mid Essex Hospital Services NHS Trust
RQM	Chelsea and Westminster Hospital NHS Foundation Trust
RQQ	Hinchingbrooke Health Care NHS Trust
RQW	The Princess Alexandra Hospital NHS Trust
RQX	Homerton University Hospital NHS Foundation Trust
RR1	Heart Of England NHS Foundation Trust
RR7	Gateshead Health NHS Foundation Trust
RR8	Leeds Teaching Hospitals NHS Trust
RRF	Wrightington, Wigan and Leigh NHS Foundation Trust
RRJ	Royal Orthopaedic Hospital NHS Foundation Trust

RRK	University Hospital Birmingham NHS Foundation Trust
RRV	University College London Hospitals NHS Foundation Trust
RT3	Royal Brompton and Harefield NHS Foundation Trust
RTD	The Newcastle Upon Tyne Hospitals NHS Foundation Trust
RTE	Gloucestershire Hospitals NHS Foundation Trust
RTF	Northumbria Healthcare NHS Foundation Trust
RTG	Derby Hospitals NHS Foundation Trust
RTH	Oxford Radcliffe Hospitals NHS Trust
RTK	Ashford and St Peter's Hospitals NHS Trust
RTP	Surrey and Sussex Healthcare NHS Trust
RTR	South Tees Hospitals NHS Foundation Trust
RTX	University Hospitals of Morecambe Bay NHS Trust
RV8	North West London Hospitals NHS Trust
RVJ	North Bristol NHS Trust
RVL	Barnet and Chase Farm Hospitals NHS Trust
RVR	Epsom and St Helier University Hospitals NHS Trust
RVV	East Kent Hospitals University NHS Trust
RVW	North Tees and Hartlepool NHS Trust
RVY	Southport and Ormskirk Hospital NHS Trust
RW3	Central Manchester University Hospitals NHS Foundation Trust
RW6	Pennine Acute Hospitals NHS Trust
RWA	Hull and East Yorkshire Hospitals NHS Trust
RWD	United Lincolnshire Hospitals NHS Trust
RWE	University Hospitals Of Leicester NHS Trust
RWF	Maidstone and Tunbridge Wells NHS Trust
RWG	West Hertfordshire Hospitals NHS Trust
RWH	East and North Hertfordshire NHS Trust
RWJ	Stockport NHS Foundation Trust
RWP	Worcestershire Acute Hospitals NHS Trust
RWW	Warrington and Halton Hospitals NHS Foundation Trust
RWY	Calderdale and Huddersfield NHS Foundation Trust
RX1	Nottingham University Hospitals NHS Trust
RXC	East Sussex Hospitals NHS Trust
RXF	Mid Yorkshire Hospitals NHS Trust
RXH	Brighton and Sussex University Hospitals NHS Trust
RXK	Sandwell and West Birmingham Hospitals NHS Trust
RXL	Blackpool, Fylde and Wyre Hospitals NHS Foundation Trust
RXN	Lancashire Teaching Hospitals NHS Foundation Trust
RXP	County Durham and Darlington NHS Foundation Trust
RXQ	Buckinghamshire Hospitals NHS Trust
RXR	East Lancashire Hospitals NHS Trust
RXW	Shrewsbury and Telford Hospital NHS Trust
RYJ	Imperial College Healthcare NHS Trust
RYQ	South London Healthcare NHS Trust
RYR	Western Sussex Hospitals NHS Trust

GUIDANCE MANUAL FOR THE NHS ADULT INPATIENT SURVEY 2009

THE CO-ORDINATION CENTRE FOR THE ACUTE SURVEY PROGRAMME

picker
INSTITUTE
making patients' views count

Last updated: 9th September 2009

Contacts

The Co-ordination Centre for the Acute Survey Programme
Picker Institute Europe
King's Mead House
Oxpens Road
Oxford
OX1 1RX

Tel:	01865 208127
Fax:	01865 208101
E-mail:	acute.data@pickereurope.ac.uk
Website:	www.nhssurveys.org

Key personnel

Sally Donovan (Manager)

Jason Boyd
Arwenna Davis
Elisabeth Garratt
Esther Howell

Adherence to the procedures outlined in this document

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

Updates

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

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

www.NHSSurveys.org

Contents

1 Introduction: patient feedback and the NHS Plan

1.1 The Care Quality Commission

The national patient survey programme was established by the Department of Health and has been operating since 2002. The Care Quality Commission took over from its predecessor, the Healthcare Commission, in April 2009 and is responsible for administering the programme. The Care Quality Commission exists to inspect the quality and value for money of healthcare, to equip patients and the public with the best possible information about the provision of healthcare, and to promote improvements in healthcare. Patients' experience of care services is at the heart of the Care Quality Commission's work: it is the aim of the Care Quality Commission and the Co-ordination Centre to make sure better care is provided for everyone.

By ensuring that organisations carry out these surveys in a consistent and systematic way it is possible to build up a national picture of people's experience and, *with care*, to compare the performance of different organisations, monitor change over time, and identify variations between different patient groups. The surveys are expected to inform local improvement activity; they are seen as an important source of information for people to help them choose between providers and for informing commissioners of services. As well as supplying the Department of Health with data to assess performance against their national targets on patient experience, the survey programme provides an important source of data for annual assessments. They have previously been used to form an 'experience of patients' indicator within the scored component of the annual health check. Additionally, results can be used by trusts in their self-assessment declarations.

1.2 The Co-ordination Centre for patient surveys

The Co-ordination Centre for the Acute Survey Programme, of which the NHS adult inpatient survey is part of, is based at the Picker Institute and works under contract to the Care Quality Commission to design, test, and co-ordinate the acute survey programme.

1.3 Why we need patient feedback

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

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

1.4 Patient feedback and the NHS Plan

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

The NHS Plan (2000) requires all NHS trusts to carry out local surveys asking patients their views on the services they have received. It is intended that measuring patients' experiences in a structured way will act as an incentive to make patient experience a real and central priority for the NHS. The national patient survey programme is an important mechanism for making the NHS more patient-focused and provides a quantifiable way of achieving this. Patient surveys can help deliver the NHS Plan commitments by:

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

1.5 Care Quality Commission assessments

Information drawn from the core questions in the Inpatients survey will be used by the Care Quality Commission in its assessment of acute and specialist trusts in England, covering the period 2009/10. More information on how the data will be used will be provided by the Commission in due course.

1.6 Measuring performance over time

In addition to the performance assessment, the Care Quality Commission will publish benchmarking data from the survey to allow trusts to make meaningful comparisons between themselves and national benchmarks based on reliable data. Asking each hospital trust to carry out an inpatient survey in a consistent way builds a detailed picture of patients' experiences in NHS hospital trusts. Information collected nationally in a consistent way is also essential to support public and parliamentary accountability. The Department of Health uses survey data to monitor improvements against the "self reported experience of patients/users" national indicator measuring progress against the national target for the public service agreement (PSA)[1]. Also, by repeating the same surveys on an annual basis, trusts will be able to monitor their own performance over time.

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

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[1] http://www.hm-treasury.gov.uk/media/3/A/pbr_csr07_psa19.pdf

1.7 Basic requirements for NHS trust inpatient survey

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

- Please let the Co-ordination Centre know your two trust contacts, their job titles, phone numbers and email addresses by **24th August 2009** to allow us to communicate vital information about the 2009 inpatient survey to you. (e-mail: **acute.data@pickereurope.ac.uk**)
- You must contact the Co-ordination Centre, by e-mail, no later than **7th September 2009** to tell us who is carrying out your survey (i.e. whether it will be carried out by an approved contractor or in-house): **acute.data@pickereurope.ac.uk**
- The survey must be carried out using a postal questionnaire
- The samples of patients must consist of the most recent consecutive discharges up to the last day of either **June 2009** or **July 2009** or **August 2009** as outlined in *Section 10 – Compiling a list of patients*
- The sampling procedure set out in this guidance must be followed. To do this, you will need to work closely with the person who draws the sample, and check carefully that this guidance has been adhered to. For further details see *Section 10 – Compiling a list of patients*
- Sample data must be submitted to the Co-ordination centre for final checks before mailing as outlined in *Section 11 – Final sampling inspection by the Co-ordination Centre*. You should aim to submit these sample files to us between **14th September** and **9th October 2009** to allow sufficient fieldwork period to maximise your response rates
- You should aim to obtain the highest response rate possible. For this survey, the target response rate is 60% (that is, you should get 500 returned questionnaires from the 850 mailed out). Three mailings will be necessary for most trusts to achieve this target. However, trusts should facilitate higher response rates through maximising their collection period by commencing work as soon as possible, and by publicising the survey to staff, patients and the community. Weekly submissions of details of response rates and helpline calls to the Co-ordination Centre will start from **24th September 2009**. A spreadsheet has been created for this purpose. For further details see Section 12 – Weekly monitoring
- The questionnaire must include the 87 core questions. See *Section 14 - The core questions and question bank*
- The standard covering letters and reminder letters (which can be found under the Inpatients section of the NHSSurveys website) must be used as outlined in *Section 15 –*

- Materials
- Two reminders must be sent to non-responders, even if a 60% response rate is already achieved. These procedures are outlined in *Section 16.6 – Sending out reminders*
- The data must be checked carefully for errors before submitting it to the Co-ordination Centre. Specific advice on how to carry this out is included in *Section 17.3 – Checking for data errors*
- The data from the core questions, and the required information about the patient sample, must be submitted to the Co-ordination Centre in the form outlined in *Section 17.4 – Submitting data to the Co-ordination Centre* by **15th January 2010**
- Two paper copies each of the questionnaire you used and the covering letters for each mailing must be submitted to the Co-ordination Centre in the form outlined in *Section 17.4 – Submitting data to the Co-ordination Centre* by **22nd January 2010**
- You must keep hard paper copies (or scanned images of all of the pages of the questionnaires, including the front page) of all questionnaires returned to you until **30th April 2010** but please do not send these to the Co-ordination Centre. These returned questionnaires may be needed to audit the data sent to the Co-ordination Centre.

1.8 Why you need this guide

Trusts have the option of conducting the survey in house or using an approved contractor (see Section 4). Whichever route you take, you will need to address the guidance in sections 1 to 13 and 18 to 20 of this guide. Sections 150, 16 and 17 cover the practicalities of mailing out the survey, following-up responses and processing data, and submitting it to the Co-ordination Centre. These sections will be most relevant to approved contractors, or trusts undertaking the surveys themselves. Section 14 contains details of the questions in the core and bank questionnaires. You can also use this guide to help you conduct the survey again locally after the national inpatients survey 2009.

2 Setting up a project team

Whether you choose to do the survey in-house, or to use an approved contractor, we recommend you set up a project team to assist you. The best way to ensure that your survey is a success is to work hard *in the beginning* to involve those people who have the most impact on patients' experiences and who will be responsible for responding to the results of the survey.

We suggest:

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

- **Involving the person responsible for drawing the patient sample in planning meetings.** It is essential that this person, and their line manager, understand the purpose of the survey and the importance of drawing the sample correctly.

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

- **Not overlooking front-line staff.** These people have the most direct impact on patients' experiences.

3 What's new for 2009?

The **2009 inpatient questionnaire** has been kept as similar as possible to the 2008 inpatient questionnaire to allow comparisons to be made between survey years. There are now **87** core questions, a net gain of seven questions since the 2008 survey. When published, the development report will contain complete documentation about all changes made to the questionnaire and can be found on our website at www.NHSSurveys.org. The changes made to the core questionnaire are listed below:

Eight new questions have been added to the core questionnaire:

- Q26. "Did you see any posters or leaflets on the ward asking patients and visitors to wash their hands or to use hand-wash gels?"
- Q27. "Were hand-wash gels available for patients and visitors to use?"
- Q71. "Were the letters written in a way that you could understand?"
- Q80-85. The five component questions making up the EQ-5D tool, comprising:
    - Mobility
    - Self-care
    - Usual activities
    - Pain/Discomfort
    - Anxiety/Depression

One question was removed from the core questionnaire:

- "Overall, how would you rate your health during the past **4 weeks**?"

Question bank redevelopment: The 2009 **question bank** has been significantly expanded following consultation with patients, trust contacts for the survey and stakeholders at the Department for Health and Care Quality Commission. The question bank now includes 203 optional questions, a net gain of 42 questions. The development report for this project will soon be available on our website.

Survey fieldwork period: The start date of the survey will be in the same week as 2008 and will start on **14th September 2009**. As in 2008, the fieldwork period for the survey will be 18 weeks. This means that the survey will run through the 2009 Christmas holidays and the date for final submission of data is the **15th January 2009**. We strongly encourage all trusts and survey contractors to submit their samples within the first four weeks of the survey (14th September – 9th October 2009) to make the most of the fieldwork period and to collect returned questionnaires for as long as possible before submitting data. This is discussed further in *Section 1112*.

Weekly submissions: Weekly submissions of response rates (outcomes) and helpline monitoring information will again be requested for each trust taking part in the inpatient survey 2009 and we ask for the first submission on **24th September 2009**. In the 2009 survey, we will be using this data to generate weekly adjusted response rate data for the Care Quality Commission by trust name. This is discussed further in *Section 12*.

Approved contractors: The contact details of many approved contractors have been updated for 2009 and can be found in *Section 5 - Commissioning a survey from an approved contractor*.

Demographics Batch Service (DBS): The NHS National Strategic Tracing Service has been replaced by the Demographics Batch Trace. The DBS traces records against the Spine Personal

Demographics Service (PDS). Patient lists will need to be checked for deaths using this new service. The DBS uses a file transfer application to send and receive files and will not accept files sent by encrypted email or through the post on physical media. You will need to ensure you are familiar with the new method for submitting patient lists to be checked.

Route of admission coding: This is a sample field first requested for the 2008 adult inpatient survey and the coding specified was “1” for emergency or urgent patients and “2” for planned or waiting list patients. However, because there are multiple codes specified on the Patient Administration System (PAS) for route of admission, different interpretations were made on how to recode these for the survey, i.e. to “1” or “2”. For 2009, please submit the data in the format prescribed by Connecting for Health. This is discussed in further detail in *Section 10.6.*

PCT information: In previous years, the Co-ordination Centre has requested “PCT codes of residence” for all patients in the sample, deriving the PCT from the patient’s home postcode using the National Administrative Codes Service (NACS)[1]. This has changed for the 2009 survey and we now require the PCT which referred the patient for acute care instead. Because this code is available on PAS, this should also reduce the workload of those carrying out the sampling for each trust. This is discussed in further detail in *Section 10.6.*

3.1 Important information to remember

Page limit: A limit has been set on the maximum number of pages that can comprise the questionnaire booklet. This limit is set to 16 sides of A4 i.e. pages 1-16. Previous research carried out by the Picker Institute has shown that a patient questionnaire with more than 16 pages can result in a dramatic decrease in response rate. We recommend font size 12 for all questions and response options.

Patient record number: The patient record number is vital for the survey process in that it allows sample and response information to be matched in a manner that isolates the patients’ names from their reporting of hospital experience. Information about the minimum font size and location, and what action to take if this number is removed from questionnaires, has been added to *Section 16.4 – Sending out questionnaires.*

Ethnic category: As in 2008, ethnic category will be requested in the standard 16 + 1 alphabetical format. However, during the 2008 survey there was some confusion over what data should be coded as “Z” (“not stated”). This code should be used **only** when a person had been asked for their ethnic category and had declined either because of refusal or genuine inability to choose. A blank or full-stop should still be used to indicate where ethnic category is “not known” i.e. where the patient had not been asked or the patient was not in a condition to be asked, e.g. unconscious. For most trusts, ethnic category will contain both “Z” codes **and** “blanks”. Further information can be found in section *10.6 – Create the sample file.*

Embargo on results: Trust-level findings for the national inpatient survey 2009 should not be released outside of the trust until the national results are published by the Care Quality Commission. Please continue to use the results from your in-house survey teams or approved contractor to improve services, but wait until the survey results for all trusts are published by the Care Quality Commission before promoting your results in any way (either on your website, in press releases or any other external publicity) to the local community and media. You will receive, along with communications staff in your trust, advance notice of the publication date and will have time to prepare for your local announcements once the embargo is lifted.

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[1] Now known as Organisation Data Services (ODS)

4 Deciding whether to use an approved contractor or carry out the survey in-house

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

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

4.1 Costs

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

Staff time

This is one of the largest expenditures, but it is sometimes overlooked. Be sure to include the cost of staff time, including salary and fringe benefits, and time spent away from other work. Please note that weekly submission will be required for each trust taking part in the inpatient survey 2009, involving increased staff time for both trusts and contractors.

Stationery and postage

You will need to cover the cost of stationery and postage for three mailings. The first mailing will go out to 850 patients and the second and third mailings will be sent only to non-responders. (See *Section 15 – Materials* for more details.) You will need to cover the cost of second class postage for three mailings, two of which will be greater than the standard letter rate, while the second mailing (first reminder slip) will be standard letter rate.

Freepost licence

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

Freephone service

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

Data entry

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

Design and production of reports

This requires a considerable amount of skilled staff time.

4.2 Internal resources

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

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

4.3 Timing

It is often possible to carry out small, localised surveys quickly in-house. However, even in the best of situations, other demands on staff can side-track them into other work. If you commission an approved contractor to carry out the survey, you should ensure that appropriate and realistic deadlines are set. The deadlines set by the Coordination Centre must be met in order for data to be submitted in time for the Care Quality Commission's annual assessment for 2009/10.

4.4 Quality and confidence in the findings

It is important to remember that the results of the survey will be used not only within the trust to identify areas for improvement but also by the Care Quality Commission and Department of Health to contribute to performance assessment and possibly for other uses, such as the NHS Choices website.

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

When you have decided who will carry out your survey, i.e. an in-house team or an approved contractor, you must inform the Co-ordination Centre by 7th September 2009.

5 Commissioning a survey from an approved contractor

The framework agreement set up by the Care Quality Commission covers the core survey process. Approved contractors are expected to provide the following services:

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

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

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

5.1 List of approved contractors

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

BMG Research

Contacts: Jenna Allen and Simon Maydew

BMG Research
Holt Court
Heneage Street West
Aston Science Park
Birmingham
B7 4AX

Tel:	0121 333 6006
Fax:	0121 333 6800
E-mail:	jenna.allen@bmgresearch.co.uk Simon.maydew@bmgresearch.co.uk
Website:	www.bmgresearch.co.uk

CAPITA Health Service Partners (formally NHS Partners' Research and Information)

Contact: Cheryl Kershaw and Aimi Blueman

CAPITA Health Service Partners
30 Victoria Ave
Harrogate
North Yorkshire
HG1 5PR

Tel: 01423 720212
Fax: 01473 720222
E-mail: Cheryl.kershaw@capita.co.uk; Aimi.blueman@capita.co.uk
Website: www.capitahsp.co.uk

GFK NOP

Contact: Sarah McHugh, Joy Mhonda and Lisa Endersbee

GFK NOP
Ludgate House
245 Blackfriars Road
London
SE1 9UL

Tel: 0207 890 9000 (Switchboard)
Fax: 0207 890 9744
E-mail: sarah.mchugh@gfk.com, joy.mhonda@gfk.com, lisa.endersbee@gfk.com
Website: www.gfknop.co.uk

Ipsos MORI

Contact: Kate Duxbury

Ipsos MORI
79-81 Borough Road
London
SE1 1FY

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

Marketing Sciences

Contact: Eileen Sutherland and Joy Owen

Marketing Sciences
8 St Clement Street
Winchester
Hampshire
SO23 9DR

Tel (direct): Eileen: 01962 835414
Joy: 01962 835419
Fax: 01962 840486
E-mail: esutherland@marketing-sciences.com; jowen@marketing-sciences.com
Website: www.marketing-sciences.com

MSB Ltd

Contact: Don Porter

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

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

The National Centre for Social Research

Contacts: Marian Bolden

National Centre for Social Research
Kings House
101-135 Kings Road
Brentwood
Essex
CM14 4LX

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

Patient Dynamics

Contacts: Fiona Ware and Andrew Smith

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

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

Patient Perspective

Contacts: Stephen Bruster, Chris Henderson

Standingford House
26 Cave Street
Oxford
OX4 1BA

Tel: 01865 205100
Fax: 1865 205111
E-mail: stephen.bruster@PatientPerspective.org; chris.henderson@PatientPerspective.org
Website: www.PatientPerspective.org

Picker Institute Europe

Contacts: Dianna McDonald and Angus Maxwell

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

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

Quality Health

Contacts: Dr Reg Race, Kerry Hibberd and Mandy Moore

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

Tel:	01246 856263
Fax:	01246 855644
Email:	reg.race@quality-health.co.uk; kerry.hibberd@quality-health.co.uk; mandy.moore@quality-health.co.uk
Website:	www.quality-health.co.uk

SNAP surveys

Contact: Tamara Gooderham, Emma Williams and Ralph Sutcliffe

SNAP Surveys
Mead Court
Cooper Road
Thornbury
Bristol
BS35 3UW

Tel:	01454 280860
Fax:	01454 281216
Email:	tgooderham@snapsurveys.com; rsutcliffe@snapsurveys.com; ewilliams@snapsurveys.com
Website:	www.snapsurveys.com

5.2 Contracts with survey contractors

The Care Quality Commission has recently revised the contracts that have previously been made available for use with the national patient surveys, to reflect recent shifts in the approach taken to such matters. The model honorary contracts have been replaced by a document that we shall refer to as the 'service contract'. Further details are available in *Section 6 – Data protection and confidentiality*.

These can be found on the NHSSurveys website in both Word document and template formats. The three documents that are available are:

- A briefing note about the service contract
- Guidance about the service contract
- The model service contract between the trust and the approved contractor, as organisations

The model service contract is designed to be used as a template contract; trusts and approved contractors may agree on amendments to the wording and content when using them. We suggest that the service contract is used as either an arrangement separate to the financial agreement made between a trust and an approved contractor when commissioning that contractor, or combined with the financial agreement to minimise the administrative burden. In either case, trusts should specify the following when confirming the requirements of the contractor:

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

6 Data protection and confidentiality

When carrying out your survey, you will need to ensure that you comply with the Data Protection Act 1998, and ensure that all responses are kept confidential. You will also need to comply with the NHS Code of Practice on Confidentiality (2003), which incorporates the Caldicott principles[1]. It is your legal responsibility to ensure that you meet any guarantees of anonymity or confidentiality made in covering letters and on the questionnaire form. It will also be necessary to establish appropriate contractual arrangements with any contractors (see section 5.2). Your trust's Caldicott guardian and legal advisors should advise you on these matters.

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

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

Information about the Data Protection Act 1998 can be found at the ICO – Information Commissioner's Office (http://www.ico.gov.uk)

Further guidance can be found in the Market Research Society document at
http://www.mrs.org.uk/standards/downloads/revised/legal/data_protection_social.pdf

6.1 Statements of compliance with data protection

In-house surveys

Each NHS trust has a Caldicott Guardian responsible for overseeing proper use of patient data. If you are conducting the survey in-house then, before mailing out the sample, you must submit a formal declaration (see Appendix 4), signed by the Caldicott Guardian and survey lead(s) for the trust, to the Co-ordination Centre. This declaration will certify that data shall only be displayed, reported, or disseminated in compliance with the new guidelines (see Section 6.9). Templates for

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

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

You should take particular care to ensure that your use of patient data in carrying out the survey, complies with these 6 principles. In particular, you should be aware of the flows of patient data, and the issues which these present. The Caldicott guidance and principles were incorporated into the NHS code of practice on confidentiality.

these declarations are available on the website containing the survey guidance (www.NHSSurveys.org). You must wait for confirmation of receipt from the Co-ordination Centre before you mail out your sample.

If the Caldicott Guardian is unable to make such a declaration, then the trust must use an approved contractor to ensure that appropriate standards of confidentiality and data protection are maintained.

Approved contractors

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

6.2 Keeping patient mailing data and sample data separate

Keeping names and addresses separate from either sample information or respondent data is the best way to ensure that the patient responses cannot be matched to patients who made them. For this reason, we suggest that once the sample has been returned from DBS and the 850 patients are finalised, patient names, addresses and postcodes are removed from the sample file to a "Inpatient 2009_mailing data" file. Before this is done, it is essential each patient is provided with a unique number (a patient reference number) and that this number is available and correctly matched on both the "Inpatient 2009_mailing data" file and the sample information file.

6.3 Mailing questionnaires to patients

There are two common methods practised by trusts, and advised by the Care Quality Commission, when working with approved contractors:

1. The contractor delivers pre-packed serial-numbered envelopes containing questionnaires, covering letters and FREEPOST envelopes to the trust. The trust then attaches number-matched address labels to the envelopes and sends them out to patients. Completed questionnaires can then be returned to the contractor and, by checking the record numbers on returned questionnaires, they can inform the trust which patients need to be sent reminders. This process is described in more detail in Section 16.

2. Alternatively, with the agreement of the trust's Caldicott Guardian, you may set up a written agreement between the trust and the external contractor. The Care Quality Commission will provide a set of contracts for trusts and approved contractors carrying out the survey to avoid the need for each trust to develop its own arrangements. It is strongly recommended that these documents are reviewed by each trust and approved contractor to ensure they are satisfied with them, and to amend where required.

A model service contract and supporting guidance notes are available on our website http://www.nhssurveys.org/surveys/432

6.4 Patients' names and addresses

Please note that under the data protection guidelines for patient surveys, the following principles **must** be followed:

- Trusts/contractors must undertake to keep their products up to date to ensure that security is effective and must strictly observe the following guidance. The requirements that dictate the guidelines include the Data Protection Act 1998, the Health and Social Care Act (Community Health and Standards) Act 2003, the NHS confidentiality code of practice 2003[1] (which incorporates the Caldicott principles).
- The Care Quality Commission strongly recommends that personal data such as names and addresses must be sent by trusts to contractors securely, either by post or over the Internet using an encrypted session.
- **By post**: Trusts should send the personal data to their contractor in the form of an encrypted data file. We strongly recommend that the **256-bit AES** (Advanced Encryption Standard) encryption algorithm should be used for this purpose – see below for further information on this. The password should be verbally given to a named individual at the contractor. **Passwords should never be written on CD-ROMs or diskettes or otherwise included with encrypted material sent through the post**. The encrypteddatabase should be saved onto a CD-ROM or diskette, place it in a single sealed envelope or other container, annotated "Addressee only", and this should be sent to the contractor by Royal Mail Special Delivery or through an approved courier service[2]: personal data should **not** be sent by recorded delivery.
- **Over the Internet**: An encrypted session based on the Transport Layer Security (TLS) or Secure Sockets Layer (SSL) protocol (for example as with HTTPS or SFTP) must be used. A key size of 256 bits or greater should be used. This is to ensure a high level of security, to protect against any accidental or intentional interception during the transfer of patients' details. Approved contractors should be able to provide guidance on the use of an encrypted session to Trusts.
- As the owners of the data, the method for transferring patient samples is ultimately the Trust's decision because the Trust remains legally responsible for the security and processing of the information it shares. The Care Quality Commission strongly recommends the two methods described above. Trusts wishing to send information by encrypted email will need to seek their own specialist advice. Guidance on best practice in encryption is available from NHS Connecting for Health[3].

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

6.5 Encryption of personal data

Any patient identifiable information sent between trusts and contractors should be in an encrypted format with password protection to help ensure good standards of information security. Many

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[1] http://www.dh.gov.uk/prod_consum_dh/idcplg?IdcService=GET_FILE&dID=9722&Rendition=Web

[2] Contact the Care Quality Commission for more detail on approved couriers: patient.survey@cqc.org.uk

[3] http://nww.connectingforhealth.nhs.uk/igsecurity/gpg/gpg/NPFIT-FNT-TO-IG-GPG-0004.01%20GPG_%20%20NHS%20Cryptographic%20Algorithms.pdf – this document is only accessible from NHSnet.

different encryption algorithms exist and not all of these are suitable, so both the Coordination Centre and the Care Quality Commission very strongly recommend the use of the **256-bit AES** (Advanced Encryption Standard) algorithm. There are several software tools that can be used to encrypt data in this way, the most commonly available of these being WinZip® (v9 and above)[1].

6.6 Confidentiality and contractor responsibilities

Two common methods are practised by trusts, and advised by the Care Quality Commission, working with approved contractors:

1. The contractor delivers pre-packed serial-numbered envelopes containing questionnaires, covering letters and FREEPOST envelopes to the trust. The trust then attaches number-matched address labels to the envelopes and sends them out to patients. Completed questionnaires can then be returned to the contractor and, by checking the record numbers on returned questionnaires, they can inform the trust which patients need to be sent reminders. This process is described in more detail in Section 16.

2. Alternatively, with the agreement of the trust's Caldicott Guardian, you may set up a written agreement between the trust and the external contractor. The Care Quality Commission has recently reviewed the set of contracts for trusts and approved contractors carrying out the survey. The honorary contracts used in previous surveys made named staff members of the approved contractor unpaid employees of the trust, allowing the trusts to transfer patient data in a way that does not compromise patient confidentiality and to avoid the need for each trust to develop its own arrangements. The new service contract specifies that the level of agreement for this arrangement is between the trust and the approved contractor organisation, rather than specific employees of the approved contractor. It is strongly recommended that this document is reviewed by each trust and approved contractor to ensure they are satisfied with the contract, and to allow this to be amend when and if required.

6.7 Model contract

A model contract has been drafted by the Care Quality Commission. This is an agreement between the approved contractor and the trust contracting them. By signing it, the approved contractor is obliged to keep the information confidential at all times, and to comply with the Data Protection Act 1998. It provides the trust with some recourse if any breach of the Data Protection Act were to occur, as a result of the actions of the approved contractor. The model contract also ensures that approved contractor staff members sign and abide by the service contract. The service contract is set up between the trust and the approved contractor who will have access to patients' information. The service contract describes how patients' personal data will be sent to the approved contractor, and how the data can be used.

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

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[1] http://www.winzip.com/

6.8 Patient anonymity

In-house surveys

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

Approved contractors

Patient anonymity can be achieved if there is a clear separation between the information seen by an approved contractor and the information held by the trust. Patients' names and addresses will be seen by trust staff when generating the sample, while contractor staff will usually possess both patient details and patient responses. As long as the response data supplied to trusts do not include patient record numbers or any other detail that allows individuals to be identified or linked, it can reasonably be claimed, with regard to the trust and trust staff, that patients' responses are anonymous.

6.9 Patient confidentiality

It is essential that any patient survey is conducted in such a way that patient confidentiality is respected and given a high priority. The covering letters that accompany the mailed questionnaires inform patients that their name and address will never be linked to their responses. Furthermore, patients' responses must not be presented to anyone in a way that allows individuals to be identified. For example, if a patient is known to have stayed on a particular ward, and his or her year of birth, sex and ethnic category are known from their survey responses, it might be possible to use this information to identify them. It would be unlawful to provide staff who may have had contact with respondents any information that would allow these respondents to be identified. The following recommendations are made:

Trust level

1) The raw data set should not be provided to any member of staff at the trust who do not need to view it, i.e. those who are not directly working on the project
2) If data are to be presented to other trust staff, only the aggregated totals for each question should be provided. If analysis by subgroup is carried out, the results for any group consisting of fewer than **30 respondents** should be suppressed (replaced by a dash). The data should be presented as in the following example. In this case, responses for the 'Mixed' and 'Asian' ethnic categories are suppressed (though the subgroup totals are shown):

	Q21. Were you ever bothered by noise at night from hospital staff?		
Ethnic category	**Yes**	**No**	**Total responses**
	%	**%**	**n**
White	81	19	261
Mixed	-	-	8
Asian	-	-	18
Black	79	21	52
Chinese or other	85	15	36

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

The electronic file containing the patients' names and addresses should be stored securely (i.e. password protected).

Approved contractor

1) Approved contractors must not provide raw data to the trust as a matter of course.
2) If the trust has a particular need for the raw data from the survey from the approved contractor, the contractor may provide an abridged version of this dataset to the trust upon request, providing that the steps below are undertaken first:
    a. The contractor must delete the two variables pertaining to ethnicity (e.g. both sample and response variables)
    b. The contractor must band year of birth into five age groups (18-35, 36-50, 51-65, 66-80, 80+). This process should be repeated separately for both sample and response variables. The original year of birth variables (e.g. those specifying an exact year rather than age group) must then be deleted
    c. Additional information specific to a survey that can be used to identify individual patients must also be removed. For example, admission and discharge dates on the NHS adult inpatient survey must be removed but length of stay can be calculated from the admission and discharge dates and provided to trusts. Route of admission to hospital does not need to be excluded unless the trust had fewer than 30 respondents admitted for an emergency or urgent admission or from a waiting list or planned admission
    d. Verbatim comments that could lead to any staff identifying respondents must be removed, e.g. those mentioning patient, staff, ward, or unit names[1]
    e. Receive confirmation from the trust that they have destroyed the names and addresses of the sampled patients, otherwise they will be able to identify individual patients by matching up the patient record number/serial numbers on the name and address list to those in the raw data file.

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

If data are to be presented to trust staff, only the aggregated totals for each question should be provided. If analysis by subgroup is carried out, the results for any group consisting of fewer than **30 respondents** should be suppressed. The data should be presented as in the following example. In this case responses for the 'Mixed' and 'Asian' ethnic categories are suppressed (though sub-group totals are shown):

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[1] Please be aware that there are exemptions allowing disclosure, such as the prevention of crime exemption which **might** allow disclosure of free text describing criminal matters actual or threatened. Neither the Care Quality Commission nor the Co-ordination Centre can offer legal advice on these matters; the contractor or trust must seek its own independent legal advice before disclosing patients' comments to trusts.

	Q21. Were you ever bothered by noise at night from hospital staff?		
Ethnic category	**Yes**	**No**	**Total responses**
	%	**%**	**n**
White	81	19	261
Mixed	-	-	8
Asian	-	-	18
Black	79	21	52
Chinese or other	85	15	36

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

The electronic file containing the patients' names and addresses should be stored securely (i.e. password protected). Access to the file should be given only to those individuals who have signed the service contract.

6.10 Sharing of survey data between contractors

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

6.11 Storing completed questionnaires

Completed questionnaires must be stored in a separate location to lists of patients' names, and the questionnaires kept until **30th April 2010**. All mailing lists of patients' names and addresses should be stored on a separate computer to that containing survey data. Mailing lists of patients' names and addresses should be destroyed when the mailing process is complete.

7 Ethical issues, ethics committees and research governance

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

7.1 Ethical approval for the inpatient survey

Multi-Centre Research Ethics Committee (MREC) approval has been obtained for the NHS Adult Inpatient Survey and a substantial amendment submitted for changes regarding the core questionnaire, the question bank, and the covering and reminder letters, all of which can be downloaded from the NHSSurveys website. In order to comply with the ethical approval, the survey must be carried out according to the guidelines set out in this document.

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

Your trust should notify the relevant R&D office that ethical approval has been obtained for the 2009 NHS Adult Inpatient Survey. The MREC letter of approval can be found on our website.

Further information on the ethical approval process can be found at National Research Ethics Service or by e-mailing queries@nationalres.org.uk.

7.2 Research governance requirements

The *Research Governance Framework* (2002, 2003, 2005) aims to ensure that health and social care research is conducted to high scientific and ethical standards. It spells out standards and the responsibilities of various parties involved in the research. One of the main purposes of the framework is to reduce unacceptable variations in research practice.

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

The Department of Health has confirmed to the Care Quality Commission that it would be inappropriate for individual trusts to follow the same local research governance processes as they would if the survey were a study the trust is sponsoring. As this national patient survey has multi-centre research ethics committee approval and the Care Quality Commission takes responsibility for it as sponsor, this would duplicate work and delay implementation unnecessarily.
The following table has been prepared by the Care Quality Commission and is taken from Section 3.10 of the *Research Governance Framework for health and social care (2005).* The left-hand

column sets out the responsibilities of organisations providing care and the right-hand columns sets out the arrangements made by the Care Quality Commission for patient surveys. If you are required to seek approval from your research governance lead, you are advised to present this information to your Research and Development Manager in support of your request.

7.3 Responsibilities of NHS organisations who are carrying out research

Research Governance Framework	**Care Quality Commission sponsored 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. Trusts should notify their Research and Development Managers of the survey.*
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 the Care Quality Commission assessments, the Department of Health national monitoring of the relevant PSA target, and local quality improvement initiatives. Detailed guidance is issued to survey leads regarding the publicity of the results and its impact on patient care.*
Be aware of current legislation relating to research and ensure that it is implemented effectively within the organisation.	*This requirement is not specific to this survey.*
Ensure that all research involving participants for whom they are responsible has ethical approval and that someone with the authority to do so has given written permission on behalf of the care organisation before each study begins.	*The Care Quality Commission as sponsors of the study have sought ethics approval from MREC. There is a designated lead for each survey who is appointed by the Chief Executive.*
Ensure that no research with human participants, their organs, tissue or data, begins until an identified sponsor, who understands and accepts the duties set out in this framework, has confirmed it accepts responsibility for that research.	*The Care Quality Commission as sponsors have undertaken steps to ensure that all the duties of the sponsors listed in Section 3.8 of the Research Governance Framework are followed thoroughly.*
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.	*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.*

Research Governance Framework	**Care Quality Commission sponsored patient surveys**
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 appropriate contract with the trust. These procedures are specifically detailed in the guidance notes.*
Put and keep in place systems to identify and learn from errors and failures.	*The Care Quality Commission also undertakes consultations with the trusts in order to ensure that the errors and failures are reported back to the Care Quality Commission. The survey programme is constantly evaluated and reviewed in light of these.*
Put and keep in place systems to process, address and learn lessons from complaints arising from any research work being undertaken through or within the organisation.	*This requirement is not specific to this survey.*
Ensure that significant lessons learnt from complaints and from internal enquiries are communicated to funders, sponsors and other partners.	*The Care Quality Commission maintains a helpline facility, which can be used by patients or trusts to report any complaints. Similar arrangements are in place with the Co-ordination Centre who are commissioned by the Care Quality Commission 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 monitoring of trusts performance by the Care Quality Commission*

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[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).

8 Collecting data from non-English-speaking populations

The patients who respond to your survey should be representative of all of the patients who use the trust, so it is important that groups with limited understanding of English are not excluded. The core questionnaire and the question bank have been written in as **plain language** as possible to facilitate optimum understanding by all respondents. The questions have also been tested with patients from a range of ethnic categories.

For this survey, translated questionnaires are not being mailed to patients since it is not possible to identify non-English-speaking patients, or their specific language, from patient records before questionnaires are sent out because language spoken is not usually included on patient administrative systems. Therefore, the first contact with them will have to be in English.

There are a number of strategies you can adopt to facilitate the process of collecting the views of people with a limited understanding of English:

- It is good practice to offer help or interpretation services to those who might require them. You can do this by subscribing to a specialist interpreting service, most of which offer telephone interpretation on a pay-as-you-go basis. This normally involves a three-way conversation between you (or your helpline operator), the patient and the interpreter (Note that trusts may already have arrangements with such a service). If you are a trust that intends to conduct the survey using an in-house team, and you do not have access to such a service, please contact the Co-ordination Centre for further advice
- A multi-language leaflet template is available on our site, and this can be included with your first and third mailings. Trusts and approved contractors can use this leaflet by inserting their appropriate helpline number. This gives directions in the 20 most common non-English languages spoken in England and also in EasyRead (routed to a separate number run by Mencap to help those with learning disabilities)
- Many households include at least one **competent English speaker** who can help the patient to fill in a questionnaire. In practice, this is often the most efficient way of gathering data from non-English-speakers, although it is not ideal, as there is no control over the way in which a patient's family or friends translate questions or interpret their responses, and it does not allow the patient to answer the questions themself.

9 Timetable

The survey fieldwork period for 2009 is 18 weeks. We recommend making full use of this to maximise response from younger and black and minority ethnic (BME) groups as previous research shows that these groups take longer to respond[1]. The best way to optimise the length of available fieldwork is to ensure that you generate your sample promptly (i.e. within the recommended four week sample checking period) and mail out your questionnaire packs promptly once permission has been received. Dissemination of the results to all staff, and to the local community and media, can only start after the survey has been completed so this will take additional time to complete.

If you commission an approved contractor, much of the work will be done by them, but you will still have to be involved in some of the stages of the process, marked in **bold** in the table below. If you are using an approved contractor for the survey, they will provide you with a timetable that might differ slightly to the suggested time periods below. As long as the specified three mailings take place and data is submitted to the Co-ordination Centre no later than the **15th January 2009**, the timetable provided by the contractor should take precedence over the suggested intervals below.

Week	Task	See Section
1	**Inform Co-ordination Centre who is carrying out your survey by 7th September 2009 (in-house or using an approved contractor)**	4 & 5
1	**Decide on questions to be included in the survey (i.e. select from question bank or use the core questionnaire)**	14
1	**Draw sample of patients to be included in the survey**	10
1	**Check sample for deceased patients using hospital records**	10.2
1	**Submit sample list to DBS to check for deceased patients**	10.4
1 - 4	**Submit anonymised sample to Co-ordination Centre before starting mailing process**	11
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 service contract is signed**	5.2 & 15.2
1	Print questionnaires and covering letters.	15.115
2	Set up FREEPOST address and helpline	16.1 & 16.2
2	Establish system for responding to telephone enquiries	16.2
2	Establish system for booking in questionnaires	16.5
3	Send first weekly response rate and helpline monitoring form to Co-ordination Centre	12
3	**Check your own trust's records again for any patient deaths**	10.2
3-8	**Stick labels on pre-packed numbered questionnaires and reminders supplied by approved contractor (if NOT using a service contract)**	16.4

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[1] For details of this research carried out by the Picker Institute Europe see

http://www.nhssurveys.org/Filestore/documents/Extension_of_fieldwork_for_inpatient_survey_2007.pdf

3-6	Send out first questionnaires	16.4
3-14	Continue to respond to telephone enquiries	16.2
3-14	Log and process returned questionnaires	16.5
3-14	Enter data	17
6-9	**Check your own trust's records again for any patient deaths**	10.2
6-9	Send out first reminders to non-responders	16.6
7-10	Be prepared for a small peak in telephone calls as first reminders received	16.2
9-12	**Check your own trust's records for any patient deaths**	10.2
9-12	Send out second reminders to non-responders	16.6
18	Complete data entry	17
18	Check data for errors	17.3
18	Send data to Co-ordination Centre (by **15th January 2010** at the latest)	18 & 19
19	Send two copies of the questionnaire used, all covering letters and a copy of the checklist to the Co-ordination Centre (by **22nd January 2010** at the latest)	11) & 12) 13)
19	Begin analysing trust's results and writing report	19
20+	**Disseminate results to staff, patients and the public**	20
	You must keep hard paper copies (or scanned images of all of the pages of the questionnaires, including the front page) of all questionnaires returned to you until **30th April 2010**	

10 Compiling a list of patients

This section explains how to draw a sample of patients. This task will need to be carried out by a member of staff at the NHS Trust. In hospital trusts, the sample will normally be drawn from the Patient Administration System (PAS). Prior to sending out questionnaires, the list will also have to be checked by the Demographics Batch Service[1] (DBS) to identify deceased patients.

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

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

10.1 Compile a list of eligible patients

1) Select the month of inpatient discharges in which your survey sample will end. You should start counting back from the last day of **either** June 2009 **or** July 2009 **or** August 2009. For optimal consistency, sample the same month as was used for the 2008 inpatient survey. If you have good reason to believe that this month was irregular in a way that would generate an unusual sample, your next choice should be the most recent month you can manage. If you change month of sampling, please inform the Co-ordination Centre for our records.

2) Compile a list of 900[2] adult (**aged 16 and over**) inpatients consecutively discharged alive from your trust working back from the last day of the sampling month. That is, once you have decided on the latest date of patient discharge you will include in the sample (i.e. 30th June 2009 **OR** 31st July 2009 **OR** 31st August 2009), you should count back through the list of patients discharged live from the trust, including all eligible patients, until you have 900 patients. Trusts can sample back as far as the **1st January 2009** to generate their sample, if required.

Note

Some trusts have a much lower discharge rate than others. If necessary, a trust can include all patients discharged back as far as the 1st January 2009 to generate their sample of 900 adult inpatients submitted to DBS.

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

The list should **include**:

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

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[1] The Demographics Batch Service (DBS) is the replacement service for the NHS Strategic Tracing Service (NSTS) batch trace.

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

The list should **exclude**:

- deceased patients
- children or young persons aged under 16 years at the time of sampling[1]
- obstetrics/maternity service users, including spontaneous miscarriages (see Glossary)
- patients admitted for planned termination of pregnancy
- psychiatry patients (see Glossary)
- day cases
- private patients (non-NHS)
- any patients who are known to be current inpatients[2]
- patients without a UK postal address[3] (but do not exclude if addresses are incomplete but useable, e.g.: no postcode).

10.2 Treatment Centres

Patients who stayed as an inpatient at a NHS treatment centres at the trust are eligible for inclusion in the sample for the 2009 inpatient survey, provided they meet the criteria above. These patients should be flagged up by inserting a ‘1’ in the appropriate column on Table 1.

Checks for deceased patients

One of the most reliable and up-to-date sources of information on patient deaths is your own trust’s records. **It is essential that you check that your trust has no record of a patient selected for the survey having died at your trust.** Relatives are likely to be particularly upset if they receive a questionnaire or reminder from the trust where their relative died. Clearly, patients may also have died at home or while under the care of another trust, so you still need to check with the tracing service (DBS) as well.

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

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

You are also advised to check your hospital records for any further deaths prior to posting the second and third mailings, and to ensure that approved contractors are advised immediately if any patients in the sample die during the survey period.

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[1] Please do not exclude patients treated at children’s hospitals as such sites do treat patients who are sixteen years and over and therefore eligible for inclusion in the survey.

[2] **Current inpatients:** Trusts are instructed to exclude current inpatients from the sample when generated. This should be the only time current inpatients are excluded from the survey process. When checks for deceased patients are carried out immediately prior to each mailing, do not check for, or exclude, current inpatients at these times. This improves the comparability of samples between trusts and thus reduces bias.

[3] Patients whose address is in the British Islands (Isle of Man, the Channel Islands) are eligible for inclusion in the survey.

10.3 Checks carried out by the trust

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

- **Deceased patients**. Check hospital records do not have a record of a patient's death from a subsequent admission or visit to hospital
- **Overnight stay**. Check that patients had at least one overnight stay in hospital. Patients are considered to have had an overnight stay if they were admitted as an inpatient and occupying a bed at midnight, e.g. patients who are admitted as an inpatient on Day 1 and discharged on Day 2 are considered to have had a single overnight stay regardless of their admission time or discharge time. Day cases and outpatients are **not** included in this survey
- **Current inpatients**. Check that none of the patients are known to be current inpatients in your trust (or elsewhere, if possible)
- **Patient ages**. Check that all patients are aged 16 or over at the time of sampling
- **Postal addresses**. Exclude any addresses that are outside the UK
- **Incomplete information**. Check for any records with incomplete information on key fields (such as surname and address) and remove those patients. However, do not exclude anyone simply because you do not have a postcode for them. Only remove a patient if there is insufficient name or address information for the questionnaire to have a reasonable chance of being delivered. The more cases that are removed at this stage, the poorer the sample coverage and the greater the danger of bias
- **Duplications**. Check that the same patient has not been included more than once
- **Obstetrics/maternity service user**. Check that the list does not include maternity service users. Please ensure that no episode of a patient's care has a maternity speciality code
- Check again that none of the patients were admitted for a **termination of pregnancy**
- **Psychiatry patients**. Check that the list does not include psychiatry patients
- **Private patients**. Remove any private patients from the sample
- **Patients treated at private hospitals**. Remove any patients who were treated by the trust as NHS patients in private hospitals.

10.4 Submit the patient list to the Demographics Batch Service (DBS)

Before sending out the questionnaires, the list of patients should be checked for any deaths by the Demographics Batch Service (DBS).

The DBS has replaced the NHS Strategic Tracing Service (NSTS) batch trace. The DBS enables users to submit and receive a file containing relevant patient records electronically using dedicated client software. The patient records in the file are matched against the NHS Spine Personal Demographics Service (PDS).[1]

Create a trace request file

Using your list of patients, you need to create a correctly-formatted batch trace request file to send to DBS. This file should be in the same format as that previously used by NSTS (this will include a header row, body and trailer row).

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[1] The PDS is a national electronic database of NHS patient demographic details. The PDS does not hold any clinical or sensitive data such as ethnicity or religion.

For each patient you will need to include as a minimum:

- NHS number and full date of birth (yyyymmdd) *OR*
- Surname, first name, gender and date of birth

Residential postcode is not essential but can be included but note that there must only be a single space in the middle of postcode. Due to the way addresses are recorded throughout the NHS, it is very difficult to get an exact match on address lines. For this reason, do not include address lines in the trace request file.

Submitting the trace request file

While the format of the request file is broadly consistent with that used by NSTS, the way in which the file is submitted to DBS differs. The DBS does **not** accept the transfer of files by encrypted emails or on physical media. Instead, **request and response files must be transferred electronically using the dedicated DBS client software**. The DBS client software should have already been installed on a server within your trust. Please speak to a member of your IT department if you do not know how to access and use the application. If your IT department cannot help, contact the DBS implementation team at: cfh.dbs-implementation@nhs.net and they should be able to advise you.

If you have been set up to use DBS, then once you have created the request file, it should be placed in the client in-box. The DBS client will then send the file to the Spine and you will receive an email to say that file was received. The DBS processes the file overnight and it should be ready the following morning. You will be notified by email when the file has been processed.

The response file

The DBS will return a header row, response body and trailer row. The response will be in two parts:

- The response containing all the data supplied in the request record, together with a trace outcome indicator. The main record is returned in all cases.
- An additional response, which is returned only when there is a single unique match. It is on this additional response that patients found to be deceased will be indicated.

Further information is available from nww.cfh.nhs.uk/demographics/dbs.

Note

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

10.5 When the patient file is returned from DBS

The trace response file returned from DBS can be used to identify any patients that have died (indicated by a letter ‘D’) and therefore need to be deleted from the sample file. This will reduce the numbers in your sample list slightly.

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

If you have more than 850 patients remaining on your list

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

If you have fewer than 850 patients remaining on your list

If your patient list has fewer than 850 patients after deceased patients have been removed, you **MUST** contact the Co-ordination Centre on 01865 208127 or email Acute.data@pickereurope.ac.uk. If possible, the next most recently discharged patients after the sample will need to be added to create a sample of 850 patients, although these must also be checked by DBS.

> Important note
>
> You are aiming for **a response rate of at least 60%**, which means that you should have about 500 completed questionnaires if you send questionnaires to 850 patients. You will be able to maximise your response rate by following this guidance carefully, and you will need to send out two reminders. It is **not** acceptable to try to boost the number of responses you receive by including more patients when compiling the sample of 850 for the survey as this would bias the survey. The Co-ordination Centre will only be able to accept responses from the patients in your list of 850 that have been correctly sampled and mailed. (See section 10.12 for the accepted options for increasing your sample size)

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

10.6 Create the sample file

An example of the spreadsheet you should complete has been included below. This can be downloaded from our site (http://www.nhssurveys.org/surveys/411) and is entitled "*Sample construction spreadsheet*". The column headings will match to the validated spreadsheet produced by the Co-ordination Centre for final submission of data and so it will be advantageous for you to use this spreadsheet. Save this file as <NHStrustname>_Inpatients2009.

This file has three purposes:

1) It will be used to keep a record of which patients have not returned questionnaires so that reminders can be sent to them.
2) It will be used to generate weekly response rates for your trust that must be forwarded to the Co-ordination Centre every Thursday from **24th September 2009** until the closing date of the survey.
3) 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 Co-ordination Centre when the survey is completed.

Table 1 – Sample construction spreadsheet of patient details

Patient record number	**Title**	**Initials**	**Surname**	**Address1**		**Address5**	**Postcode**	*Year of birth*	*Gender*	*Ethnic category*	*Day of admission*	*Month of Admission*	*Year of Admission*	*Day of discharge*	*Month of discharge*	*Year of discharge*	*Length of Stay*	*Main Specialty on discharge*	*Referring PCT*	*Treatment centre admission*	*Route of admission*	*Day of questionnaire being received*	*Month of questionnaire being received*	*Year of questionnaire being received*	*Outcome*	**Comments**
1001	Mrs	AM	Abbot		--		AB1 1YZ	1934	2	A	5	8	2009	11	8	2009	6	100	5LS	0					3	Informed that patient had died
1002	Mr	EC	Ahmed		--		AB2 6XZ	1970	1	J	20	7	2009	12	8	2009	23	101	5LT	1	11	22	10	2009	1	
					--																					
1849	Ms	K	Yoo		--		AB4 7MX	1950	2	R	17	6	2009	31	8	2009	75	300	5LS	0						
1850	Ms	F	Young		--		AB9 5ZX	1946	2	A	14	8	2009	31	8	2009	17	100	5GT	0	22	6	11	2009	1	

Important note about table 1

The headings of Table 1 are in three different colours:
Bold black headings: these columns contain information on patients' names, addresses and comments that may allow them to be identified. This information should be deleted from all files sent to the Co-ordination Centre. This data, along with a copy of the Patient Record Number should be removed from the sample file after when the 850-patient sample is finalised to create the "mailing data" file
Red italic headings: these columns should be completed during the sampling phase and submitted to the Co-ordination Centre prior to mailing for final inspection (see Section 0) and at the conclusion of the survey
Green italic headings: these columns should be completed when the patient responds to the survey, either by returning a completed questionnaire, or the trust is notified the patient will not be participating (patient deceased, moved address, too ill, or called to opt out).

The following information is compiled using hospital records:

- Title (Mr, Mrs, Ms, etc.)
- Initials (or First name)
- Surname
- Address Fields [1]
- Postcode

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[1] The address should be held as separate fields (e.g. street, area, town, and county), consistent with the address format required by the DBS.

Note

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

- The **Year of Birth** should be included in the form of NNNN.
- **Gender** should be coded as 1 = male and 2 = female.
- **Ethnic Category**[1] coding is the same as for last year's inpatient survey. The ethnicity of a person is specified by that person, and should be coded using the 17 item alphabetical coding specified by NHS Connecting for Health[2]. The codes are as follow:

National Codes:

White

A	British
B	Irish
C	Any other White background

Mixed

D	White and Black Caribbean
E	White and Black African
F	White and Asian
G	Any other mixed background

Asian or Asian British

H	Indian
J	Pakistani
K	Bangladeshi
L	Any other Asian background

Black or Black British

M	Caribbean
N	African
P	Any other Black background

Other Ethnic Groups

R	Chinese
S	Any other ethnic group
Z	Not stated[3]

- **Day** of the month of admission (1 or 2 digits; e.g. 7 or 26)*

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[1] It is acknowledged that patient records might not always contain complete data on patients' ethnic category. However, this field should be included wherever possible. This data is required in order to evaluate non-response from different ethnic categories. This is in keeping with the aims of the Care Quality Commission and Department of Health to be more responsive to all ethnic groups and to ensure all groups are appropriately represented in their assessments.

[2] These codes can be found in the NHS Data Dictionary provided by Connecting for Health on the following website:
http://www.datadictionary.nhs.uk/data_dictionary/attributes/e/enh/ethnic_category_code_de.asp?shownav=1

[3] The code "Z" should only be used if the patient was asked for their ethnic category but refused to provide it. If this code is missing for any other reason, ethnic category should be left blank in the sample information.

- **Month** of admission (1 or 2 digits; e.g. 9 or 10) *
- **Year** of admission (4 digits; e.g. 2009) *
- **Day** of the month of discharge (1 or 2 digits; e.g. 2 or 30) *
- **Month** of discharge (1 or 2 digits; e.g. 9 or 10) *
- **Year** of discharge (4 digits; e.g. 2009) *
- **Length of Stay** (Units = Days)[1]
- Main Specialty on Discharge is recorded in the form NNN as outlined in the Updated National Specialty List which was implemented on the 1 April 2004. See http://www.datadictionary.nhs.uk/web_site_content/supporting_information/main_specialty_and_treatment_function_codes.asp?query=treatment specialty&rank=1&shownav=1
- **Referring PCT** should be coded using the **first three** characters of the PCT character codes of the PCT which will be billed for the care of that patient. For the most up-to-date list of PCT codes, please see the Connecting For Health data set, "Primary Care Trusts" (http://www.connectingforhealth.nhs.uk/systemsandservices/data/ods/data-files)
- **Treatment Centre Admission** should be coded as '1' for patients who spent any part of their inpatient stay at an NHS treatment centre within the trust, and coded as '0' if they did not
- **Route of Admission** coding has changed for the 2009 inpatient survey. When creating the sample file, please include the two-digit descriptive code as used within the NHS Commissioning Data Sets. A blank or full-stop should be used if this information cannot be obtained for a patient. See http://www.datadictionary.nhs.uk/data_dictionary/attributes/a/add/admission_method_de.asp?shownav=1

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

1) **Patient record number.** This field will be a series of consecutive whole numbers (for example, 1001 through to 1850). This number is unique for each patient. It can be seen in the example that the numbers are in ascending order, starting at 1001 at the top of the list, through to 1850 at the bottom. The patient record number will be included on address labels and on questionnaires. Later, when questionnaires are returned (whether completed or not), you (or the approved contractor) will be able to use these numbers to monitor which patients have returned their questionnaires and to identify any non-responders, who will need to be sent reminders. If an approved contractor is used, you will need to agree with them on the range of serial numbers that will be used for your patients. Please note: this number should be available in, and correctly referenced for, every patient dataset for this survey.
2) **Day of questionnaire being received**. This can only be completed if and when a questionnaire is received by the trust or approved contractor. It should be a one or two digit numerical response e.g. N or NN, **not** a date format e.g. 12/09/09.
3) **Month of questionnaire being received**. This can only be completed if and when a questionnaire is received by the trusts or approved contractor. It should be a one or two digit numerical response, **not** a date format.
4) **Year of questionnaire being received**. This can only be completed if and when a questionnaire is received by the trusts or approved contractor. It should be a four digit numerical response, **not** a date format.

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[*] Date fields must be supplied in separate columns (e.g. date, month, and year).

[1] Calculate this by subtracting the admission date (day/month/year) from the discharge date (day/month/year). For example, if discharge date = 15/7/2009 and admission date = 14/7/2009, the Length of Stay = 1. Do not use any other type of unit to calculate Length of Stay (i.e. do not use hours/minutes/seconds). All patients in the sample should have a Length of Stay greater than or equal to 1 day.

5) The **Outcome** field will be used to record which questionnaires are returned to the freepost address, or are returned undelivered, or which patients opt out of the survey, etc.
    - 1 = Returned useable questionnaire
    - 2 = Returned undelivered by the mail service or patient moved house
    - 3 = Patient died
    - 4 = Patient reported too ill to complete questionnaire, opted out or returned blank questionnaire
    - 5 = Patient was not eligible to fill in questionnaire
    - 6 = questionnaire not returned (reason not known).

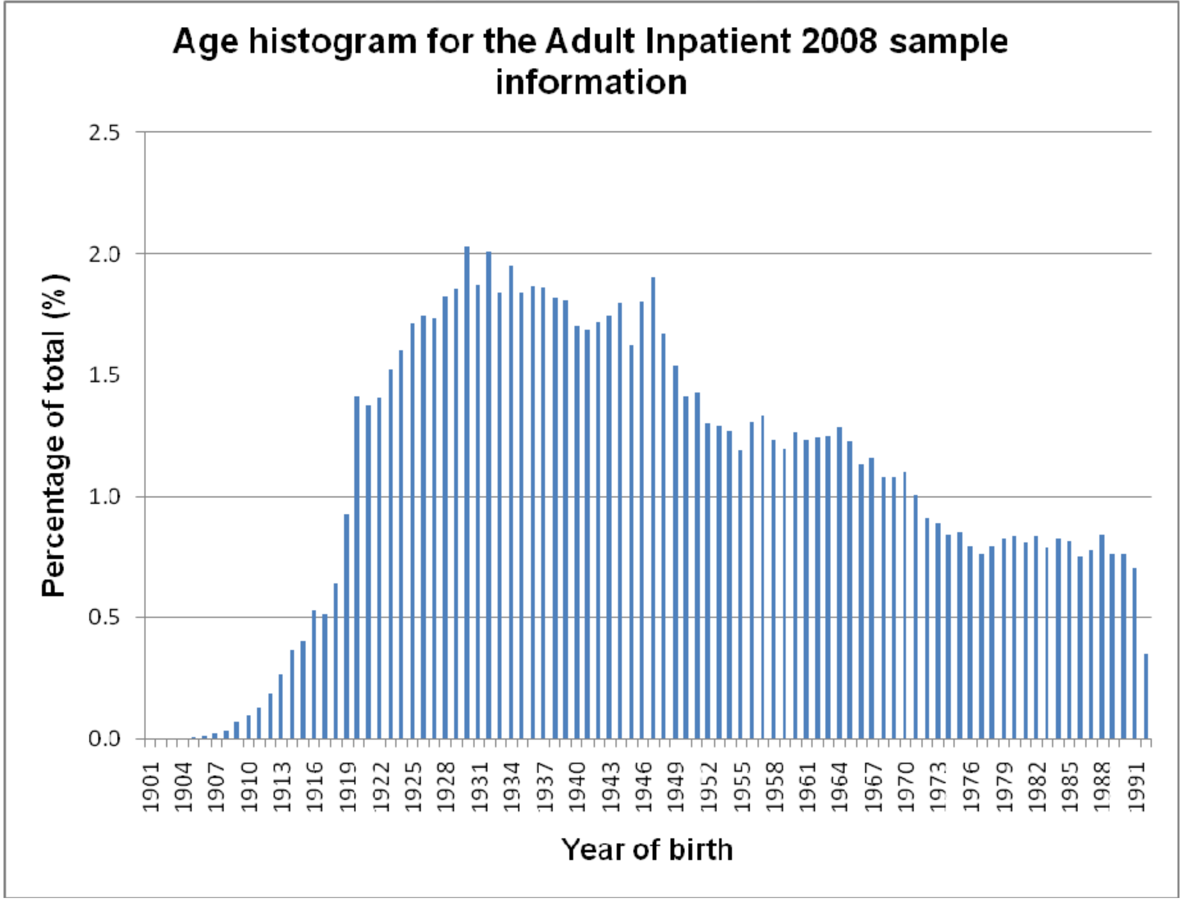
    The outcome column is left blank at first if the survey has not been returned (on table 1 you can see that Ms Yoo has not yet returned her questionnaire).
6) The **Comments** column is useful for recording any additional information that may be provided when someone calls the helpline – for example, to inform you that the respondent has died or is no longer living at this address.

10.7 Distribution of patient ages

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

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

Table 2 – Example Age Histogram for Inpatient survey



10.8 Distribution of patient gender

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

10.9 Check for other sample errors

Further information on the sampling errors made in the 2008 inpatient survey can be found on the following webpage:
http://www.nhssurveys.org/survey/699

Using this document to check for any errors may reduce delays caused by mis-sampling and consequentially improve your response rate to this survey.

10.10 Separating mailing details from sample information

At this point you should transfer the names, address and postcode for each patient in the sample to a new file. The patient reference number (PRN) for each patient should be copied to the new file, so that the two datasets are connected using the unique PRN. It is essential to ensure this number is correctly applied to the two datasets. Save this new file as “Inpatients2009_mailing data”.

This file should be used for mailing purposes: it will be used to check for deceased service users prior to reminder mailings and will be cross-referenced with the sample file (<NHStrustname>_Inpatients2009) to identify service users who will need to be sent reminders.[1]

As this "Inpatients2009_mailing data" file will only be used occasionally during the survey, we recommend you keep this file encrypted. The mailing data file should be destroyed when the last mailing process is complete.

For patient confidentiality reasons, **it is essential that you do not keep patient name and address details in the same file as their survey response data**.

10.11 Table 3 – Example mailing file

Patient record number	**Title**	**Initials**	**Surname**	**Address1**	**Address2**	**Address3**	**Address4**	**Address5**	**Postcode**
1001	Mrs	AM	Abbot	14 Station Road	London				AB1 1YZ
1002	Mr	EC	Ahmed	Flat 7	Short Street	Oxford			AB2 6XZ
					--				
1849	Ms	K	Yoo	The Maltings	Birch Road	Little Abington	Cambridge	Cambs	AB4 7MX
1850	Ms	F	Young	634 Tyne Road	Newcastle-Upon-Tyne	Tyne and Wear			AB9 5ZX

10.12 Sharing the patient sample file with an approved contractor

If you are working with an approved contractor and have a contract in place relating to the transfer of patient identifiable information (i.e. names and addresses) both the sample file ("<NHStrustname>_Inpatients2009") **and** the mailing file ("Inpatients2009_mailing data") file should be sent to the contractor staff in encrypted format (see *Section 6.5 - Encryption of personal data*).

If you are working with an approved contractor, but have chosen to mail out the questionnaires yourself, within the trust, you should supply them with just the sample file (this will resemble **Table 1 – Sample construction spreadsheet of patient details** but with the patient names, addresses and postcodes removed). The contractor can use this list to record the outcome codes, but you

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[1] As shown in table 1(section 10.6), the 'outcome' field in the sample file is used to record which questionnaires are returned completed, or are returned undelivered, or which patients opt out etc...

should ensure that the contractor is kept up to date with any information that comes directly to the trust about patient deaths, etc.

10.13 Making more use of the survey locally

Up to this point, this section of the guidance has described in detail how sampling must be undertaken to provide the basic required sample of 850 patients for the national survey. In addition to this minimum requirement, though, your trust may wish to use the NHS adult inpatient survey as an opportunity to gather further data beyond that required by the Care Quality Commission. Increasing the sample size is a good way to do this.

Increasing the sample size for the survey may be helpful if, for example, you wish to:

- Analyse or compare results for specific subgroups (for example, patients treated at different sites or patients of different ethnicities) in more detail than would be possible from a sample of 850 patients. By increasing the sample size you can ensure that you have a large enough sample of patients from each group[1]
- Cover a very wide range of questions without exceeding the maximum questionnaire length of 16 pages for the main survey. If you wish to ask a large number of questions from the question bank, it would be possible to use two different versions of the questionnaire with a different selection of questions included, each going to a separate sample (please note however that all patients in the core sample of 850 must receive an identical questionnaire which must include the core questions).
- Alternatively, if your trust regularly treats very large numbers of patients, you may wish to draw an extra sample of patients to survey additionally to those included in the main survey. For example, you could select patients discharged in a different time period from those in the national survey and send them questionnaires either at the same time as or at some point after the national survey. By running the survey locally in addition to the national survey, you can establish a more frequent pattern of reporting enabling you to track experience over time, or test the impact of recent quality improvement initiatives. If you decide to carry out an inpatient survey locally at the same time as the national survey you will need to ensure that you are sampling two distinct and separate groups of patients which do not overlap. Guidance for carrying out a local survey will be available on request in early September, please email advice@pickereurope.ac.uk or call 01865 208127. All materials will be available on the "local surveys" website from the end of September at http://www.nhssurveys.org/localsurveys.

If you are using an approved contractor for the survey then they will be able to advise you on the best way to increase your sample size to achieve your specific goals. If you are not using an approved contractor, then the coordination centre will be able to advise on any queries you might have via e-mail at advice@pickereurope.ac.uk or call 01865 208127. However, before you decide to do this, there are some important points to consider:

- The core sample for the 2009 inpatient survey **must** be drawn as specified in this guide; any deviation from the guidance may make it impossible for the Care Quality Commission to use the data that you collect. It is therefore essential that any additional sample drawn can be easily distinguished from the core sample, and that it is drawn in such a way as to not interfere with selection of the core sample.
- If you are planning to undertake surveys more frequently than the national programme, then you should consider how any increased sample here will fit with the additional surveys you will be undertaking. From autumn 2009, guidance for carrying out a local survey will be

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[1] See section 18 for more information on the reliability of data based on different numbers of respondents.

made available upon request so that organisations that wish to do so can begin to plan for future local surveys, and all materials will be available from the end of September at: www.nhssurveys.org/localsurveys .

To summarise

If you do choose to increase your sample size, it is essential that you ensure that the sample of patients you draw according to the requirements for the national survey can be easily distinguished from any additional patients you include in the sample. Your approved survey contractor or the coordination centre will be able to advise you on this.

You must **only** send the Co-ordination Centre data for the 850 patients sampled according to these guidelines, and these patients **must** be those discharged most recently. If you decide to carry out an inpatient survey locally at the same time as the national survey you will need to ensure that you are sampling two distinct and separate groups of patients which do not overlap.

11 Final sampling inspection by the Co-ordination Centre

Trust data should still be checked for errors and received back from DBS before being forwarded to the Co-ordination Centre. An anonymised sample file[1] **must** be submitted to the Co-ordination Centre **prior** to the first mailing. This is to allow us to make final quality control checks. All columns *in red italics* in **Table 1 – Sample construction spreadsheet of patient details** must be submitted, but name, address and postcode details must be removed.

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

The Co-ordination Centre will be checking for extraordinary errors. These are more visible when viewing data from many trusts at one time. For this reason, samples will be checked as collated files. Emails discussing any sample anomalies will be returned to the trust or approved contractor which provided them on Tuesday of each week **at the very latest**. Initially, we will be working to the timetable included below but, if sufficient samples are submitted during a week, we hope to be able to respond to trusts and approved contractors earlier.

Making the most of the fieldwork period

Because certain demographic groups (specifically younger patients and those from non-white ethnic categories) have been shown to take longer to respond to patient surveys, we strongly recommend that files are submitted within the four weeks specified for sample checking. The best way to ensure you can do this is to prepare before the start date of the survey (14th September 2009). You can do this by:

1) Allocated sufficient time to the individual who will generate your sample to allow them to generate it, dispatch it to DBS, and to respond to queries or corrections specified by your contractor or the Co-ordination Centre
2) Discuss the work with your Caldicott Guardian to ensure they are available to sign off any necessary documents for the survey
3) Ensure your trust is registered with DBS and that the person who submits your sample to them understands their requirements – problems with data submitted to tracing services is one of the most significant obstacles in mailing out your survey in good time. Also, do not assume you are registered – please check this ahead of time.
4) Printing of questionnaires and assembly of mailing packs can take place before the sample is signed off. Please ensure that the envelopes are left open though so that you can check the correct label is applied to the correct questionnaire. This means that you should decide on your questions as early as possible so arrange the times for any meetings that will discuss the questionnaires as early as possible.

Your first mailing should take place as soon as possible after your sample has been approved by the Co-ordination Centre but **must not be later than seven days** after this. A large time lag increases the likelihood of patients having died between the sample file being received back from

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[1] Created by removing the patients' names, addresses and postcodes.

DBS and the questionnaire being received, increasing the risk of distress to family members and complaints to your trust.

For the 2009 adult inpatient survey, the specified sample submission dates are:

Date sample received	Date sample returned
14th-21st September 2009	22nd September 2009
22nd -28th September 2009	29th September 2009
29th-5th September 2009	6th October 2009
6th -12th October 2009	13th October 2009

Samples should be submitted to the Co-ordination Centre by the **12th October 2009**. If they are not, there is a risk your trust will not have enough time to correct any problems in the sample and complete the survey with an acceptable response rate. Major errors may then result in the data from the trust being excluded from the relevant Care Quality Commission assessments.

Trusts which have not submitted their sample for checking by the **12th October 2009** will be contacted by the Co-ordination Centre to discuss any problems you are having and how we can help with the process. However, if samples are not received by the **19th October 2009**, then we are required to notify the Care Quality Commission of this and they will contact you to discuss any implications for inclusion in Care Quality Commission produced data.

Further information can be found on the sampling errors made in the 2008 inpatient survey on the following webpage:

http://www.nhssurveys.org/survey/699

12 Weekly monitoring

The Co-ordination Centre requires weekly submissions of outcome data and helpline calls for each trust taking part in the 2009 inpatient survey. First submission of data must be made on Thursday **24th September 2009**[1], and every Thursday thereafter until the final date of submission. An Excel spreadsheet is available on our website (www.nhssurveys.org) which **must** be used to return this information to the Co-ordination Centre. This information should be emailed to the Co-ordination Centre (acute.data@pickereurope.ac.uk) by the end of the workday every Thursday throughout the survey. However, weekly monitoring forms do not have to be returned for week 14 (24th December 2009) and week 15 (31st December 2009) due to the conflict with the Christmas holiday period. Submissions should be resumed for the following week (7th January 2010) for all trusts, even if data has already been submitted by the trust.

Weekly submissions only apply to the core sample of patients

Important note

It is important that the structure of the Excel weekly monitoring spreadsheet is not altered and that the correct file name is used when submitting the data.

For trusts carrying out the survey in-house:

When the data is submitted, the file name **must** be in the following format:
IP08_<trust code>_<week of submission>.xls

e.g. IP09_RAC_1.xls (first submission of monitoring data on 24th September 2009)
IP09_RY2_4.xls (fourth submission of monitoring data on 22nd October 2009)

For approved contractors:

When the data is submitted, the file name **must** be in the following format:
IP08_<contractor code>_<week of submission>.xls

e.g. IP09_ACP_1.xls (first submission of monitoring data on 24th September 2009)
IP09_ACY_4.xls (fourth submission of monitoring data on 22nd October 2009)

Each approved survey contractor should use their unique 'contractor code' (which were first allocated for the maternity survey 2007). If you do not know your contractor code, please contact the Co-ordination centre.

12.1 Response rate

The information submitted should contain the following data:

- The total number of patients in your sample i.e. the total number of all those included in the first mailing,
- The number of patients in each outcome field (see Section 10.6, point 5)

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[1] This submission must be made regardless of whether mailing has commenced.

This will allow the Co-ordination Centre to monitor progress at a trust level and to identify trusts that may need assistance. It will also allow us to provide the Care Quality Commission with regular updates on response rate at a trust level.

12.2 Helpline monitoring

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

- The overall total number of calls received by the helpline for this survey. This total should also include the calls listed below:
- The total number of calls that led to completion of the questionnaire using the helpline (this should include completions via translation services)
- The total number of calls seeking assistance with language and translation (this should include completions via translation services)
- The total number of calls that led to completion of the questionnaire using translation services

Examples

If a caller rang the helpline and completed the questionnaire over the phone using translation services, then this call should be recorded in all four ‘categories’.

If a caller completed the questionnaire over the phone (and did not require translation services) this call should be recorded in the ‘overall total’ and the ‘total number of calls that led to completion’ (ie first and second categories).

If a caller rang the helpline to opt out of the survey or to ask a question (and did not require translation services), this call should just be recorded in the ‘overall total’ number of calls’ (ie first category).

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

13 Publicising the survey

13.1 Pre-survey communication with staff

The best way to ensure your survey is a success is to work hard in the beginning to involve those people who have the most impact on patients' experiences and who will be responsible for responding to the results of the survey. We suggest you put together a small team of people who are key stakeholders and involve them in decisions. Groups to consider include:

- Caldicott Guardian
- Board members
- Doctors, nurses and other health care staff
- Members of patient groups with a special interest in the trust
- Patients and carers
- Medical records personnel or Patient Administration System (PAS) staff
- Managers
- Staff or directors responsible for:
    - Clinical governance
    - Patient advice and liaison service (PALS)
    - Quality improvement
    - Strategic planning

Keeping everyone informed

Notify as many staff members as possible about the survey, in case patients contact the trust asking questions about the questionnaire they have received. Patients can be expected to ask receptionists, doctors, nurses, patient liaison officers, or the Chief Executive's office about the survey, even when your covering letters give contact details for the survey manager(s) and the dedicated helpline. Notify front line staff and executive offices that a survey is being conducted, and give them the name and number of a contact person. Survey manager(s) should be prepared to respond to these calls quickly.

Staff could be notified of the survey through a variety of methods:

- Electronic (e.g. e-bulletins, website, intranet)
- Paper-based (e.g. staff briefings, newsletters, flyers, posters)
- Face-to-face (e.g. meetings, presentations and events)

Appendix 2 includes information which you can tailor for publicising the survey to staff.

13.2 Publicising the survey externally

To help promote involvement and maximise response rates, the survey can be publicised to patients and the public through a number of ways, for example:

- Send a press release to the local media to raise awareness of the survey and gain publicity just before the survey takes place. Information to help you draft a press release is shown in *Appendix 3*. Talk to your hospital's press office for more ways in which you can gain publicity locally.
- Put up posters around the hospital which show the importance the trust places on gathering patient feedback. To be most effective at increasing your response rate, posters should be

put up in the hospital during the sampling period (i.e. during the month(s) from which your sample of inpatients will be drawn).

To encourage patients to respond, we recommend you illustrate how the trust has acted on the results of the previous inpatient surveys carried out by the trust. Patients are likely to be more motivated to take part in the survey if they can see tangible outcomes from a previous survey.

14 The core questions and question bank

Each trust must include in their survey at least the 87 core questions. There is a pre-designed core questionnaire on the NHSSurveys website, which includes only these questions. Trusts can also choose to use an “enhanced” questionnaire, where additional questions of local relevance may be added from a question bank of validated questions. A questionnaire compilation tool is available on the NHS Surveys website to help you create your survey

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

1) The **core inpatient questionnaire**, which comprises 87 core questions.
2) The **enhanced questionnaire**, which includes the 87 core questions, with additional questions added from the bank of validated questions.

14.1 The core questionnaire

The core questionnaire consists of 87 questions on 12 pages. These questions cover the issues that have been found to be most important to patients and **must** be included in your survey. The front page of the questionnaire explains the purpose of the survey and gives instructions on how to fill it in. In the pages that follow, the survey questions are divided into sections that broadly follow the patient's experience.

14.2 Using the question bank

The core questionnaire covers all the compulsory questions you need to ask to comply with the NHS national patient survey programme. However, you might want to ask more questions on some topics, and you can do this by adding from the question bank. All of the questions have been designed and tested by the Co-ordination Centre for the Acute Survey Programme and are available online, with the questions arranged in the appropriate sections.

A username and password (chosen by individual users) need to be entered, to enable identification of each questionnaire, allowing it to be saved and retrieved.

For the question bank tool to work effectively, please use Microsoft Internet Explorer rather than other web browsers, such as Mozilla Firefox.

Deciding which questions to use

A PDF document containing all of the questions from the inpatients question bank can be found on the NHS Surveys website: http://www.nhssurveys.org/surveys/413. You may prefer to look at this document first to help you decide which questions to include in your survey. However, we recommend that you use the compilation tool to create your questionnaire as this will format the survey and filter instructions as you select questions.

When deciding which questions to include, you may want to consider the following:

- **Comparison of results over time:** if you want to compare your results with the previous national adult inpatients survey, then remember to select the questions you used before.

- **Evaluation of service improvement initiatives:** if you are implementing service improvements, you may wish to include questions which measure the success of these initiatives.
- **Monitoring progress against national targets / trust-wide initiatives**

The core questions are clearly marked and must be included; additional questions can be selected for inclusion if your trust deems them to be particularly relevant at a local level. Please take care to maintain question order when adding from the question bank and check the question skips are appropriate for your new questionnaire. Data from these additional questions should not be submitted to the Co-ordination Centre at the end of the survey. Also take particular care not to exceed 16 pages of questions as this may cause a decrease in response rate.

Do not exceed 16 pages in your questionnaire. This could result in a significantly reduced response rate for your survey findings.

Generating the questionnaire

Once you have selected all the questions you want to include in your survey, the questionnaire can be generated by clicking ‘Generate PDF’. This produces a questionnaire in PDF format, which can then be saved on the website so you can return to it in future, saved to disk or printed out. **When you have finalised your questionnaire, remember to check the question numbering is consecutive and the ‘Go to’ instructions are correct**.

The Care Quality Commission holds the **copyright** to the inpatients survey tool. To protect this please:
a) acknowledge in all published materials the Care Quality Commission’s ownership of and copyright for the tool
b) do not use the tool for generation of revenue

15 Materials

15.1 Printing questionnaires

Questionnaire layout

The questionnaire is rigorously tested in the format of the core questionnaire. All questionnaires used by trusts should emulate this format and should be comprised of the following:

- Two columns of questions on each page
- Questions should be presented with a consecutive question number, followed by the exact question wording used in the core questionnaire, and then each of the response options presented on a separate line beneath the question, for example:

Q33. Did doctors talk in front of you as if you weren't there?

1 ☐ Yes, often

2 ☐ Yes, sometimes

3 ☐ No

- Please do not arrange the response options horizontally across the page, rearrange the question options, or change the order of the questions in the questionnaire.

Number of pages

It is practical to ensure that the number of pages in a questionnaire is a multiple of four so that sheets can be printed double-sided on A3 paper and folded to make an A4 booklet, stapled in the middle. If pages are stapled at the corner, there is a greater chance that some pages will become detached and get lost. The core questionnaire, available in PDF format on the NHSSurveys website, is designed to fit onto 12 sides of A4 paper.

Number of questionnaires

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

Including other information in the mailing packs

No other material should be included in the questionnaire packs because of the unmeasureable impact upon response rates to the survey. Additionally, the Multi-region ethics board judged that inclusion of additional material that they had not viewed would invalidate the ethical approval they have given for the adult inpatient survey and the survey would therefore not be able to proceed.

15.2 Trust headed paper

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

15.3 First mailing

You will need 850 of each of the following items:

- Printed questionnaires
- Large envelopes for mailing questionnaires to patient
- Labels for addressing envelopes
- Labels for sender address on reverse of envelopes
- FREEPOST envelopes for return of questionnaires
- Covering letters using the trust's letterhead
- Multi-language helpline sheet (recommended)[1].

15.4 Second mailing (first reminder)

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

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

15.5 Third mailing (second reminder)

The second reminder should replicate the first mailing, and you will need to send this to around 45-65% of the original sample, depending on the number of responses to the previous two mailings. The following items are needed:

- Printed questionnaires
- Large envelopes for mailing questionnaires to patient
- Labels for addressing envelopes
- Labels for sender address on reverse of envelopes
- FREEPOST envelopes for returning questionnaires
- Reminder letters
- Multi-language helpline sheet (if used in first mailing).

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[1] This document can be found on our website alongside the cover letters. The languages covered by this document are: Arabic, Bengali, Chinese (Cantonese), Farsi /Persian, Guajarati, Hindi, Kurdish, Chinese (Mandarin), Punjabi, Tamil, Thai, Turkish, Urdu, French, Italian, Polish, Portuguese, Russian, Somali, Spanish.

16 Implementing the survey - practicalities

16.1 Setting up a FREEPOST address

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

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

16.2 Setting up a FREEPHONE line

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

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

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

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

I have a specific comment, complaint or question about my care or treatment. Who can I contact at the trust?
Patients can be referred to the trust's PALS, the complaints manager or patient services manager. Approved contractors should be given the contact details of the PALS office or an appropriate member of trust staff so that they can refer callers to that person.

The person to whom the questionnaire is addressed is unable to understand the questionnaire.
Relatives or carers may call to pass on this information. In some cases, they may offer to complete the questionnaire for the patient, but this is only advisable if there is a good chance that the responses are a true reflection of the patients' views.

The person to whom the questionnaire is addressed has died.

Even with the use of a deceased patients tracing service, it may not be possible to identify all deceased patients, particularly those who have died most recently. It is very important that staff who take the calls are aware of this possibility and are prepared to respond sensitively to such calls. These patients should be logged as outcome = three (patient deceased).

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

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

I do not wish to participate in this survey

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

Making a record of the calls

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

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

16.3 Covering letters

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

16.4 Sending out questionnaires

Mailing labels

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

We recommend using the mail merge feature in a word processing package to create the mailing labels from the database of patient names and addresses. **It is essential that the patient record number is on each address label,** as this has to be matched with the number on the front of the questionnaire. The label should not include any other information except the patients' name, address and postcode details, and the patient record number.

Note on the patient record number (PRN)

The patient record number is a unique number allocated to all patients at the start of the survey that allows their responses to be kept separate from their name and address, but allows matching up of the response data with the sample data. It also allows them to identify themselves if they contact the trust or contactor without needing to provide name and address information. This should be centrally placed and large enough to be visible to all patients. The Royal National Institute of the Blind recommends the number be printed in size 14 font and located inside the box on the lower half of the front page of the questionnaire.

If patients delete this number from the cover page and then returned the questionnaire, please add their response information in an additional row to the bottom of the data file before submitting it to the Co-ordination Centre. Please do not attempt to match this data to a non-responder of similar demographics, but instead inform the co-ordination centre about this respondent and they will be treated as an additional patient to the sample.

Questionnaire packs

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

1) A questionnaire **numbered with the patient record number**. The number must match the number on the address label, and the number on the list of patient details.
2) A covering letter.
3) The multi-language helpline sheet (recommended)
4) A large envelope, labelled with the FREEPOST address on it.
5) These items should be packed into an envelope that has a return address on the outside. This should be the contact at the NHS trust, or the approved contractor.

Postage

The postage may exceed the standard letter rate. It is essential that the appropriate postage rate is paid. The Royal Mail has recently published revised mailing prices; previous quotes for mailing may be out-of-date.

Approved contractors – mailing questionnaires

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

Approved contractors – trusts mailing questionnaires

If an approved contractor is carrying out most of the work but not operating under a service contract, they should send pre-packed questionnaires to the trust for mailing out. The envelopes should be clearly marked with the patient record numbers so that trust staff can match these with their patient list and put on appropriate patient address labels.

16.5 Booking in questionnaires

When questionnaires are received, match up the patient record numbers against the list of patients, so that you can record (in the *outcome* column) which patients have returned questionnaires and will not therefore need to be sent reminders. You will need to keep paper copies (or scanned pictures of all of the pages of the questionnaires, including the front page) of any questionnaires that are returned to you until **30th April 2010**, but please **do not** send these to the Co-ordination Centre.

Approved contractors

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

16.6 Sending out reminders

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

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

Approved contractors

If a trust is using an approved contractor but is carrying out the survey mailing in-house, the approved contractors should send the pre-packed envelopes bearing the patient record numbers of the non-responders to the acute trust. Again, the envelopes should be clearly marked with the patient record number so that those carrying out the mailing can correctly label the address for each patient record number.

First reminders

The first reminder should be sent to patients who have not responded after **one to two weeks**. The first reminder should reach the participant while they are still in possession of the first questionnaire, and the optimal time for this will vary between trusts. We recommend approximately **ten** days between the mailing day of the first questionnaire and the mailing day of the first reminder.

The standard first reminder is available in Microsoft Word format on the NHSSurveys website for you to download. It can be printed on A5. It has been given ethical approval so no changes are permitted. Two paper copies of the reminder letter you use must be sent to the Co-ordination Centre when you submit your data at the end of the survey.

Second reminders

Second reminders should be sent out approximately **two to three weeks** after the first reminder to patients who have not yet responded. Again the optimal time will vary between trusts and experience is the best guide for choosing mailing dates.

The envelopes should include the following:

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

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

Remember that you should check your trust's own records for deaths before sending out reminders.

17 Entering data

The data must be submitted to the Co-ordination Centre in the appropriate format by the deadline of **15th January 2010**. If an approved contractor is used, they will be responsible for all of the data entry and checking, and when the survey is completed they should submit the data to the Co-ordination Centre in the correct format and supply the trust with an anonymised data set (see Section 6 on data protection issues).

17.1 Entering and coding data from the core questionnaire

The data should be entered into the pre-designed Excel file, which can be found in the inpatient 2009 survey section of the NHSSurveys website.

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

- Each row records one patient's responses to the survey
- For each question, the small number next to the box ticked by the patient should be entered as the response
- If a response is missing for any reason, it should be left blank, or coded as a full stop (.)[1]
- If two boxes are ticked (where only one should be ticked), the response should be left blank or coded as a full stop (.)
- For most questions, each column corresponds to one survey question. However, there are some exceptions to this rule. For multiple response questions Q85 and Q86 that gives the instruction “Tick all that apply", each response option is treated as a separate question.

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[1] 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 (.).

Example

Q85. Do you have any of the following long-standing conditions? (**Tick all that apply)**

1 ☑ I have deafness or severe hearing impairment
2 ☐ I have blindness or are partially sighted
3 ☐ I have a long-standing physical condition
4 ☐ I have a learning disability
5 ☑ I have a mental health condition
6 ☐ I have a long-standing illness
7 ☐ I do not have a long-standing condition

Responses to each part of this question are coded: **1 if the box is ticked**
0 if the box is not ticked[1]

Q77 takes up three columns in the data file, labelled as follows:

Column headings	**Q85_1**	**Q85_2**	**Q85_3**	**Q85_4**	**Q85_5**	**Q85_6**	**Q85_7**
Codings for this example	1	0	0	0	1	0	0

- When saving this file to submit data to the Co-ordination Centre, please save only the first sheet as a worksheet, rather than saving the whole file as a workbook; the Co-ordination Centre does not need the additional formula pages.

17.2 Entering data from enhanced or customised questionnaires

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

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

You will need to send the data from **only** the 87 compulsory core inpatient survey questions to the Co-ordination Centre. To do this, you will need to transfer those columns of data that cover the responses to those 87 questions to the pre-designed Excel file available on the website. The columns of this standard Excel file are headed with the numbers corresponding to the question numbers in the core inpatient questionnaire. They also include the wordings of the 87 core inpatient questions so that you can match them up. It is essential that you check carefully that the columns of data you select from any larger data set correspond to the 87 core inpatient survey questions.

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[1] Please note: if a respondent does not answer any part of a multiple response question, (ie does not tick any of the response options) then it should be left blank or coded as a full stop (.)

17.3 Checking the data for errors

For the 2009 national inpatient survey, trusts and contractors are required to submit raw (‘uncleaned’) data to the Co-ordination Centre. For clarification, raw data is created by the following:

1) All responses should be entered into the dataset, regardless of whether or not the respondent was meant to respond to the question (e.g. where patients answer questions that they have been directed to skip past, these responses should still be entered).
2) Where a respondent has ticked more than one response category on a question, this should be set to missing in the data. The **exception** to this is for the ‘multiple response’ questions Q85 and Q86, where respondents may tick more than one response option.
3) Where a respondent has crossed out a response, this should not be entered in the data. Where a respondent has crossed out a response and instead ticked a second response option, this second choice should be entered into the data.
4) Where a respondent has given their response inconsistently with the formatting of the questionnaire but where their intended response is nonetheless unambiguous on inspection of the completed questionnaire, then the respondent’s intended response should be entered. For example, where a patient has written their date of birth in the boxes for Q79, but written their year of birth in at the side of this, then the respondent’s year of birth should be entered.
5) For the year of birth question, unrealistic responses should still be entered except following rule 4) above. For example, if a respondent enters ‘2009’ in the year of birth box, this should still be entered unless the respondent has unambiguously indicated their actual year of birth to the side.
6) Once the data has been entered, no responses should be removed or changed in any way except where responses are known to have been entered incorrectly or where inspection of the questionnaire indicates that the patient’s intended response has not been captured. This includes ‘out-of-range’ responses, which must not be automatically removed from the dataset. Responses in the dataset should only be changed before submission to the Co-ordination Centre where they are found to have been entered inconsistently with the respondent’s intended response.

A data cleaning document will be provided during the fieldwork that will document all filtering and cleaning carried out on the collated dataset by the Co-ordination Centre so that trusts and approved contractors can duplicate this process after submitting the raw data to the Co-ordination Centre.

17.4 Submitting data to the Co-ordination Centre

The data from the core questions of the 2009 inpatient survey must be supplied to the Co-ordination Centre as one anonymised Excel file that includes information about the patient sample and responses. To comply with the Data Protection Act, name and address details must not be sent to the Co-ordination Centre.

Required file format

Please submit the file to the following specifications:

- Use Microsoft Excel Worksheet (not Workbook). Any version of Excel is acceptable
- The file name must be in the form <NHStrustName>_Inpatient2009.xls
- Use one row of data for each patient in the sample
- Use one column of data for each item of patient information or response

- Patients who are missing their Patient Record Numbers should be added to the bottom of the list, and not matched to patients with similar demographics
- Missing data should be left blank or coded as a full stop (.). [1]

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

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

Field	Format	Data codes	Comments
Patient record number	N, NN, NNN or NNNN		The unique serial number allocated to each patient by the trust or approved contractor administering the survey.
Year of birth	NNNN		Format this simply as a number, not in date format.
Gender	N	1 = male 2 = female	If gender is not known or unspecified, this field should be left blank or coded as a full stop (.)
Ethnic category	N	**National Codes:** **White** A British B Irish C Any other White background **Mixed** D White and Black Caribbean E White and Black African F White and Asian G Any other mixed background **Asian or Asian British** H Indian J Pakistani K Bangladeshi L Any other Asian background **Black or Black British** M Caribbean N African P Any other Black background **Other Ethnic Groups** R Chinese S Any other ethnic group	Ethnic category should be included if the information is available.

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

Field	Format	Data codes	Comments
		Z Not stated	
Day of admission	N or NN		For example, if the patient was admitted on 15th July 2009, this column should read ‘15’.
Month of admission	N or NN		For example, if the patient was admitted on 15th July 2009, this column should read ‘7’.
Year of admission	NNNN		For example, if the patient was admitted on 15th July 2009, this column should read ‘2009.
Day of discharge	N or NN		For example, if the patient was discharged on 20th July 2009, this column should read ‘20’.
Month of discharge	N or NN		For example, if the patient was discharged on 20th July 2009, this column should read ‘7’.
Year of discharge	NNNN		For example, if the patient was discharged on 20th July 2009, this column should read ‘2009.
Length of Stay	N to NNNN		For example, if the admission date was 15/7/2009and the discharge date was 16/7/2009, the Length of Stay = 1.
Main Specialty of Discharge	NNN	Use the codes as outlined in the Updated National Specialty List which was implemented on the 1st April 2004	Only supply the ‘Main specialty’ for each patient on their DISCHARGE.
Referring PCT	NNN	Use the character codes provided by Connecting for Health to complete this field	Only use the FIRST three characters of the PCT code
Treatment centre admission	N (0 or 1)	This flags whether the patient spent time in a NHS treatment centre at the trust	If the patient did spend any time as an inpatient in a treatment centre, this should be recorded as ‘1’; if they did not then it should be recorded as ‘0’.
Route of admission	NN	Please use the two-digit descriptive code as used within NHS Commissioning data sets	A blank or full-stop should be used if this information cannot be obtained for a patient.
Day of receiving questionnaire	N or NN	This is the day you received a returned questionnaire from a respondent, or are notified that the patient will not be participating in the survey (patient deceased, moved	For example, if the questionnaire was received on 15th October 2009, this column should read ‘15’.

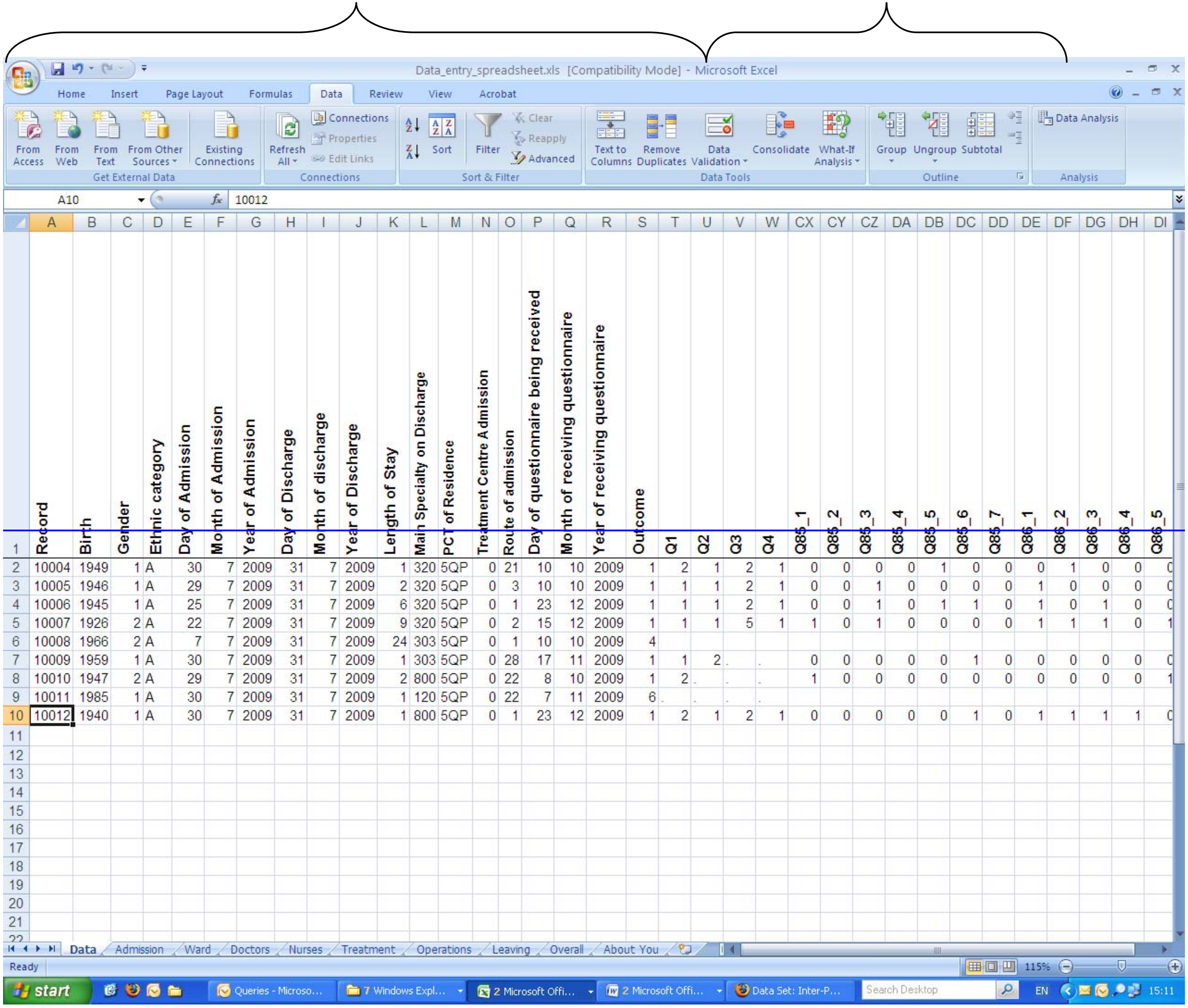
Field	Format	Data codes	Comments
		address, too ill, or called to opt out)	
Month of receiving questionnaire	N or NN	This is the month you received a returned questionnaire from a respondent, or are notified that the patient will not be participating in the survey (patient deceased, moved address, too ill, or called to opt out)	For example, if the questionnaire was received on 15th October 2009, this column should read ‘10’ (as October is the 10th month of the year).
Year of receiving questionnaire	NNNN	This is the year you received a returned questionnaire from a respondent, or are notified that the patient will not be participating in the survey (patient deceased, moved address, too ill, or called to opt out)	For example, if the questionnaire was received on 15th October 2009, this column should read ‘2009.
Outcome of sending questionnaire	N	1 = Returned useable questionnaire 2 = Returned undelivered by the mail service or patient moved house 3 = Patient died 4 = Patient reported too ill to complete questionnaire, opted out or returned blank questionnaire 5 = Patient was not eligible to fill in questionnaire 6 = questionnaire not returned (reason not known)	Remember to fill in all the blank cells with 6s when the survey is complete.
Responses to each of the 87 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 Co-ordination Centre.

NB: To comply with the Data Protection Act, name and address details must not be sent to the Co-ordination Centre.

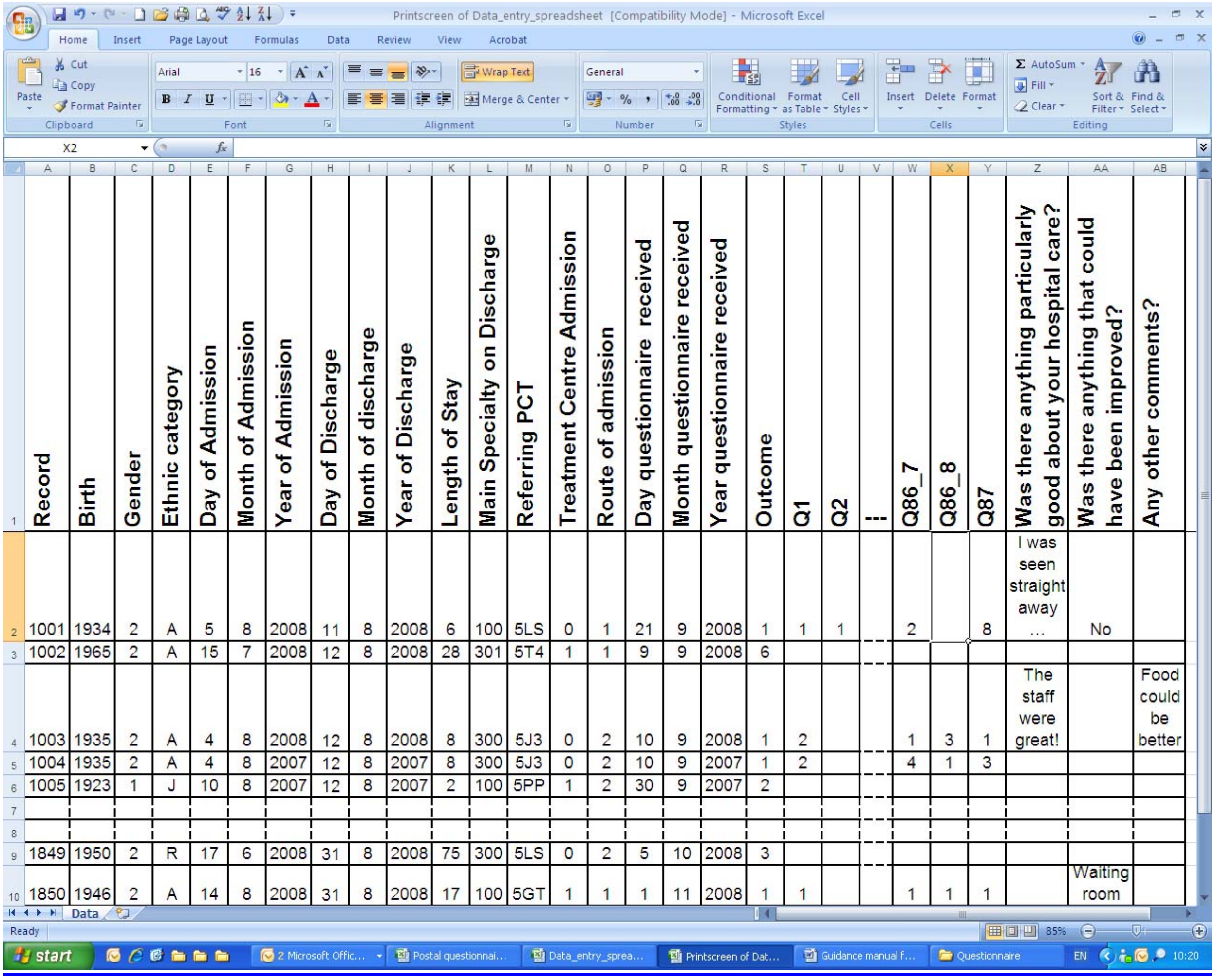
Table 4 is an example of the columns of data to be included in the file. Your file should have 850 rows (one for each patient included in your sample). You will notice that there are several blank cells in the response section of the file. This is because the file includes a row for every patient in the sample, but you will only have responses from about 60% of the patients (that is, those who have returned a completed questionnaire, and who will therefore have an outcome code "1").

Table 4 – Example of data file to be submitted to Co-ordination Centre

Patient Sample Information **Patient Response Information**



	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	V	W	CX	CY	CZ	DA	DB	DC	DD	DE	DF	DG	DH	DI
1	Record	Birth	Gender	Ethnic category	Day of Admission	Month of Admission	Year of Admission	Day of Discharge	Month of discharge	Year of Discharge	Length of Stay	Main Specialty on Discharge	PCT of Residence	Treatment Centre Admission	Route of admission	Day of questionnaire being received	Month of receiving questionnaire	Year of receiving questionnaire	Outcome	Q1	Q2	Q3	Q4	Q85_1	Q85_2	Q85_3	Q85_4	Q85_5	Q85_6	Q85_7	Q86_1	Q86_2	Q86_3	Q86_4	Q86_5
2	10004	1949	1	A	30	7	2009	31	7	2009	1	320	5QP	0	21	10	10	2009	1	2	1	2	1	0	0	0	0	1	0	0	0	1	0	0	0
3	10005	1946	1	A	29	7	2009	31	7	2009	2	320	5QP	0	3	10	10	2009	1	1	1	2	1	0	0	1	0	0	0	0	1	0	0	0	0
4	10006	1945	1	A	25	7	2009	31	7	2009	6	320	5QP	0	1	23	12	2009	1	1	1	2	1	0	0	1	0	1	1	0	1	0	1	0	0
5	10007	1926	2	A	22	7	2009	31	7	2009	9	320	5QP	0	2	15	12	2009	1	1	1	5	1	1	0	1	0	0	0	0	1	1	1	0	1
6	10008	1966	2	A	7	7	2009	31	7	2009	24	303	5QP	0	1	10	10	2009	4																
7	10009	1959	1	A	30	7	2009	31	7	2009	1	303	5QP	0	28	17	11	2009	1	1	2	.	.	0	0	0	0	0	1	0	0	0	0	0	0
8	10010	1947	2	A	29	7	2009	31	7	2009	2	800	5QP	0	22	8	10	2009	1	2	.	.	.	1	0	0	0	0	0	0	0	0	0	0	1
9	10011	1985	1	A	30	7	2009	31	7	2009	1	120	5QP	0	22	7	11	2009	6	.	.	.	.												
10	10012	1940	1	A	30	7	2009	31	7	2009	1	800	5QP	0	1	23	12	2009	1	2	1	2	1	0	0	0	0	0	1	0	1	1	1	1	0



Record	Birth	Gender	Ethnic category	Day of Admission	Month of Admission	Year of Admission	Day of Discharge	Month of discharge	Year of Discharge	Length of Stay	Main Specialty on Discharge	Referring PCT	Treatment Centre Admission	Route of admission	Day questionnaire received	Month questionnaire received	Year questionnaire received	Outcome	Q1	Q2	---	Q86_7	Q86_8	Q87	Was there anything particularly good about your hospital care?	Was there anything that could have been improved?	Any other comments?
1001	1934	2	A	5	8	2008	11	8	2008	6	100	5LS	0	1	21	9	2008	1	1	1		2		8	I was seen straight away …	No	
1002	1965	2	A	15	7	2008	12	8	2008	28	301	5T4	1	1	9	9	2008	6									
1003	1935	2	A	4	8	2008	12	8	2008	8	300	5J3	0	2	10	9	2008	1	2			1	3	1	The staff were great!		Food could be better
1004	1935	2	A	4	8	2007	12	8	2007	8	300	5J3	0	2	10	9	2007	1	2			4	1	3			
1005	1923	1	J	10	8	2007	12	8	2007	2	100	5PP	1	2	30	9	2007	2									
1849	1950	2	R	17	6	2008	31	8	2008	75	300	5LS	0	2	5	10	2008	3									
1850	1946	2	A	14	8	2008	31	8	2008	17	100	5GT	1	1	1	11	2008	1	1			1	1	1		Waiting room	

Additional information required

The following information should also be included when submitting the data file to the Co-ordination Centre:

- **Contact details** (telephone numbers and e-mail addresses) of at least two members of trust staff (usually the main and secondary contacts) who will be available to answer any queries about the data
- **Two blank paper copies** of the questionnaires, the covering letters and the reminder letters you used
- A completed copy of the **checklist** (See Section 17.5 - Checklist).

Delivery

Data may be sent on encrypted CD-ROMs or by e-mail (see section 6 of this document for details on the recommended encryption and delivery methods to use). Hard copy documents should be posted to the address below:

Postal address:

Inpatient Survey 2009
Co-ordination Centre for Acute Survey Programme

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

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

Deadline for submission

The data must be supplied by **15th January 2010**.

17.5 Checklist

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

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

If incorrect data are submitted, it is possible that the data will be considered unreliable and will not be used by the Care Quality Commission in your trust's performance assessment and your trust's scores will be set to a minimum value. We cannot accept re-submissions of data after the deadline, and likewise data is unlikely to then be included in the Care Quality Commission assessments.

A printable version of the checklist can be found on our website at:
http://www.nhssurveys.org/survey/755

Check	Done?
1) Check that your **file name** follows the naming convention: <NHStrustName>_Inpatient2009.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 you have included data columns for **all 87 core questions**	
4) Check that you have **not** included any columns of optional questions	
5) Check that all **data are correct**, and that all values are in range	
6) Send data only for the **850 patients** consecutively discharged from your trust in the chosen month	
7) Check that all the data are in **numeric format** only (including dates)	
8) Check that you have completed the columns for the day, month and year you received the questionnaire back from patients	
9) To comply with Data Protection regulations, any **patient name and address details** must be removed before the file is sent to the Co-ordination Centre	
10) Notify the Co-ordination Centre of the **password** separately from the data file, either by email or telephone	
11) Include **two paper copies** of the questionnaire you used	
12) Include **two paper copies** of the covering letters you used for the first, the second and third mailing.	
13) Include **telephone and e-mail contact details of two people** who will be available to respond to any queries about the data	
14) Check that you have **not** included any columns of optional questions	
15) **Check again** that all data are correct, and that all values are in range!	

18 Making sense of the data

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

18.1 Using the NHSSurveys website to look at your results

Once you have entered the data from the core questions into the Excel file on the website (the Data Entry Spreadsheet), the counts and percentages of responses to each of the 87 core questions are automatically computed and displayed on the other sheets of the Excel workbook, which correspond to sections of the inpatient core questionnaire (excluding the “Other Comments” section). For each question, the numbers and percentages of respondents who gave each answer is shown. The number of missing responses will also be shown, as long as you have coded missing responses on the data sheet as a full stop (.).

18.2 Suggestions on data analysis

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

Use the data to help pinpoint problems

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

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

"Drill down" into the data

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

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

Group similar questions together to provide summary analysis

Analysing questions and presenting findings in a way that is comprehensive, logical and not overwhelming is a significant challenge. To make the data more compelling for others, and to speed up the analysis, we suggest:

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

Use statistical tests to make comparisons and subgroup analyses

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

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

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

Use patient feedback data with other data

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

Perform analysis by sub-groups

You may want to compare the answer to a survey question between two different groups to see if the differences are significantly different (e.g. the answers for men versus women, or between patients treated under different specialties). However, comparing results *within* your trust considerably reduces the number of responses in each group. This will impact upon the level of confidence you have in the results and, therefore, your ability to accurately detect differences between these groups.

Table 5 (below) shows the level of confidence you would achieve for various numbers of respondents.

Table 5: Confidence intervals*

Number of respondents	Widest Confidence Interval (+/-)[1]
50	13.9%
100	9.8%
200	6.9%
300	5.7%
400	4.9%
500	4.4%
600	4.0%

*at a 95% confidence level

If you are interested in looking at different sub-groups within your trust population (for example, patients treated at different sites in your trust), you will need to think about the number of respondents you need in each group, and how this will impact on the confidence you can have in the results. The Co-ordination Centre recommends a minimum of 100 respondents per group for comparison between sub-groups. Confidence intervals for analysis with groups of fewer than 100 respondents will be so large that there would be little certainty of detecting reliable statistical differences[2]

Example

For a trust, 400 patients responded in total. Taking a particular question, of which 50% of respondents answered '*Yes*', from the table we can see that the widest confidence interval for 400 respondents would be +/- 4.9%. We would therefore be 95% confident that the true results would be between 45.1% and 54.9% - that is, if you had surveyed the entire population of inpatients at a trust.

However, if we are looking at the results for this particular question *by eight different groups of patients* (assuming an equal number of respondents in each region), there would only be 50 respondents in each group. If there are 50 respondents and 50% answered '*Yes*', the confidence interval would be +/- 13.9%, so the true results could be between 36.1% and 63.9%.

If you are using a survey contractor to help you carry out your survey, they should be able to advise you on the minimum sample size for comparisons by particular sub-groups

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[1] This column (the widest confidence interval) shows the **maximum** margin of error for binomial estimates of proportions

[2] A **confidence interval** is an upper and lower limit within which you have a stated level of confidence that the trust mean (average) lies somewhere in that range. The width of the confidence interval gives some indication of how cautious we should be; a very wide interval may indicate that more data should be collected before any conclusions are made.

19 Reporting results

19.1 Prioritising your findings

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

Rank results by their magnitude

The most straightforward method of prioritising is to rank issues in order of the size of the problem and to focus first on those that are the greatest.

Compare your results against outside norms or benchmarks

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

Compare results within your organisation

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

Compare results over time

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

Comparison with predefined goals

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

Correlation with overall measures

Correlating patient responses to specific questions with responses to the question about overall quality of care can help focus attention on issues that are important for patients.

Predictive value on overall measures (regression analysis)

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

Ease of action

Many organisations focus initially on the issues that are easiest to improve. By demonstrating successful interventions, this prioritisation method can rally support for more difficult improvement efforts later on.

Areas of excellence

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

19.2 Writing the report

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

Tailor the document to the audience

- Use brief, succinct summaries for executive audiences.
- Use comprehensive summaries for those who will implement improvements. They will help achieve buy-in and generate action.
- A separate resource booklet or data disks/CD-ROMs with full details may be important if staff or researchers have questions.

Use graphics

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

Keep the format succinct and consistent

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

Emphasise priorities clearly

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

20 Using results for quality improvement

Arguably the most important aspect of the survey process is making use of the results to bring about improvements. It is essential that this patient feedback is used to set priorities for quality improvement programmes and to create a more responsive, patient-centred service. It should then be possible to measure progress when the survey is repeated.

20.1 Prepare in advance

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

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

20.2 Dissemination of survey results

Engage key stakeholders

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. Consider the following groups:

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

Spread the Word

Disseminating survey results entails far more than producing and photocopying a report. Consider how to share the survey results in training sessions, staff and public meetings, employee newsletters, executive communications, process improvement teams, patient care conferences, and other communications channels. You may wish to consider the following:

- Determine whether information should be shared initially with only senior-level people, or whether (and when) it should be spread further afield

- Make presentations to your trust board and to as many groups of staff as possible, each tailored appropriately for the audience
- Organise 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
- Publish results in your trust newsletter along with details of improvement plans

Promote understanding

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

- Present results in user-friendly formats. Remember not everyone will be an expert in reading graphs and deciphering data
- Communicate information in a visual way, perhaps in the form of posters which can be displayed around your organisation.
- Focus on key messages arising from the results and emphasise both the positive and negative themes
- Illustrate themes with relevant patient comments or other forms of patient feedback to put the results in context

20.3 Identify key "change agents"

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

20.4 Prioritising areas for improvement

Compare with other trusts

Compare your trust's results with the benchmarks on the Care Quality Commission website to find out where your trust performs better or worse than other trusts.

Compare Departments within your trust

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

Identify where patients report most room for improvement

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

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

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

Identify problems surrounding particular aspects of the patient experience

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

- The time waiting to be admitted to a bed on a ward
- Being given enough information about their condition or treatment
- Receiving pain relief medication quickly
- Being discharged without a delay

20.5 Develop an action plan

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

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

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

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

20.6 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 focus your improvement effort. It can be time-consuming and expensive to gather this information on a large scale. Small follow-up surveys focusing on selected groups of patients can provide valuable information and faster feedback.

20.7 Use already existing resources

The Department of Health has recently published the guide ‘Understanding what matters: A guide to using patient feedback to transform care’, which can be found on their website at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_099780. This guide may help you get the most from your survey results.

21 Glossary

Adult inpatient

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

Current inpatient

For the purposes of this survey, we define a current inpatient as a participant who meets the inclusion criteria for the survey, but is a current inpatient at any hospital in England. Please check your own trust records for any current inpatients during sampling and exclude these people from the sample during the sampling phase only. If you are aware that they are current inpatients at another trust, also exclude these people. When checks for deceased patients are carried out prior to subsequent mailings, do not check for, or exclude current inpatients.

Ethics Committee

The purpose of Research Ethics Committees in reviewing a proposed study is to protect the dignity, rights, safety, and well-being of all actual or potential research participants. A favourable ethical opinion from the committee implies that the research does protect the participant's aforementioned rights.

Multi-Centre Research Ethics Committee (MREC)

A MREC can grant a favourable ethical opinion for studies carried out in multiple regions of England. The inpatient survey operated under approval from the North West MREC and applies prior to each survey for a substantial amendment to cover any changes in questionnaire content or wording in the cover letters. The favourable ethical opinion for the study covers all NHS hospital trusts in England.

Overnight stay

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

Obstetrics/Maternity patients

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

Psychiatry patients

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

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

Research Governance Framework

This outlines the principles of good research practice and is key to ensuring that health and social care research is conducted to high scientific and ethical standards.

Appendix 1: Suggested text for pre-survey communication with staff

Example titles:

What do our patients think about the [trust name]?

Getting patients' views on the quality of care in [trust name]

Understanding patients' experiences in [trust name]

Patient views vital to drive service improvements in [trust name]

We [or NHS Trust name / Hospital name] are carrying out a survey to find out what patients' think about the care they receive.

Why are we doing another patient survey?

A survey of adult inpatients was carried out as part of the national patient survey programme in 2008. We are carrying out another survey, using the [same / a similar] questionnaire and methodology, to [track any changes in patients' experiences over time so we can continue to improve services / or to evaluate the success of quality improvement initiatives implemented since the last survey]

Obtaining feedback from patients and taking account of their views and priorities is vital for bringing about improvements in the quality of care.

When is the survey taking place?

Questionnaires will be posted to a sample of patients during [month]. Reminders will be sent to those who have not responded during [month(s)].

Patients are being asked about various aspects of their care, including [arrival at hospital, the quality of care and treatment, pain management, communication with doctors and nurses, information, and the hospital environment.]

Who is the survey being sent to?

The survey will be sent to a sample of [number] patients, aged 16 years and over, who spent at least one night in hospital during [month]. [An external survey contractor, {name}, is administering the survey so that patients' responses are anonymous]

How have the results from previous surveys been used?

Results from the 2008 inpatient survey helped to identify areas where there was most room for improvement [a summary of the key findings from the previous survey and how the trust acted on the results can be inserted here]

When will the results of this survey be available?

The results of this survey will be available in [month/date] in [location of where results will be published or shared with staff]. The survey findings will be reported in [format, e.g. a summary report, at a meeting etc…]. By working with both staff and patients we will use the feedback from this survey to further help improve patient's experiences at the trust.

Where can I find out more?

For more information about the survey, please contact [lead survey name and contact details]

Appendix 2: Suggested template text for pre-survey article for external media

Title: **[NHS Trust name] seeks patient views** **or**

Patient views vital to drive service improvements in [NHS Trust name]

Your chance to tell [NHS Trust name] about quality of care

[NHS Trust name] is carrying out a survey to find out what patients think about the care they receive. The trust plans to use this feedback to improve patients' experiences. The results will be used to help [NHS Trust name] highlight areas where they perform well and to identify the areas where there is most room for improvement.

Patients who have recently been an inpatient at [Hospital A and Hospital B] may receive a questionnaire in [month], asking about their experiences. They will be asked about various aspects of their care, including [arrival at hospital, the quality of care and treatment, communication with doctors and nurses, information, and the hospital environment.]

Obtaining feedback from patients and taking account of their views and priorities is vital for bringing about improvements in the quality of care. Results from the survey will be used to [insert purpose of survey here, e.g. to track patients' experiences of care received at the trust since the last survey was undertaken in [2008] / or to measure the impact of changes made at the trust based on feedback from the 2008 survey / or to find out if recent changes made to the service has led to an improvement in patients' experiences]

Results from the 2008 adult inpatient survey helped to identify areas where there was most room for improvement [a summary of the key findings from the previous survey and how the trust acted on the results can be inserted here]

The results of the survey will be presented in a form that does not allow any individual's answers to be identified. The results will be published by [NHS Trust name] in [month and year]

[A senior executive at the trust] says "We hope that our patients will take the time to help us with this survey. Their views are vital in helping us to find out how we are doing and how we can improve. This is an excellent way for patients to help shape the services we provide in the future."

Appendix 3: Declarations of data protection compliance

Declaration of compliance with the Data Protection Act 1998

DECLARATION

RELATING TO THE

2009 adult inpatient survey

FOR TRUSTS USING IN-HOUSE SURVEY TEAMS

While carrying out the 2009 adult inpatient survey, all trusts need to comply with:

- the Data Protection Act 1998,
- the NHS Code of Practice on Confidentiality, and
- the Caldicott principles.

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

For further information on the new guidelines, please see the "Data protection" section in the Guidance Manual for the 2009 adult inpatient survey.

I, [**insert name of Caldicott Guardian**] the Caldicott Guardian for [**insert trust name**] declare the aforementioned trust to be compliant with the Data Protection Act 1998 and will ensure that data collected while carrying out the NHS patient survey programme will conform to the guidelines set out under the section "Data protection" in the Guidance Manual for the 2009 adult inpatient survey.

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

I, [**insert name of first survey lead**] the first Survey Lead for [**insert trust name**] declare I understand the requirements of the Data Protection Act 1998 as they relate to the 2009 adult inpatient survey and will ensure that data collected while carrying out the NHS patient survey programme will conform to these requirements and the guidelines set out under the section "Data protection" in the Guidance Manual for the 2009 adult inpatient survey.

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

I, [**insert name of second survey lead**] the second Survey Lead for [**insert trust name**] declare I understand the requirements of the Data Protection Act 1998 as they relate to the 2009 adult inpatient survey and will ensure that data collected while carrying out the NHS patient survey programme will conform to these requirements and the guidelines set out under the section "Data protection" in the Guidance Manual for the 2009 adult inpatient survey.

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

Appendix 4: Declarations for additional data analysts

Declaration of compliance with the Data Protection Act 1998

DECLARATION
RELATING TO THE

2009 adult inpatient survey

Additional data analysts

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

For further information on the new guidelines, please see the “Data protection” section in the Guidance Manual for the 2009 adult inpatient survey.

I, [**insert name of Caldicott Guardian**] the Caldicott Guardian for [**insert trust name**] declare the aforementioned trust to be compliant with the Data Protection Act 1998 and will ensure that data collected while carrying out the NHS patient survey programme will conform to the guidelines set out under the section “Data protection” in the Guidance Manual for the 2009 adult inpatient survey.

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

I, [**first additional data analyst**] the first additional data analyst for [**insert trust name**] declare I understand the requirements of the Data Protection Act 1998 as they relate to the 2009 adult inpatient survey and will conform to these requirements and the guidelines set out under the section “Data protection” in the Guidance Manual for the 2009 adult inpatient survey.

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

I, [**second additional data analyst**] the second additional data analyst for [**insert trust name**] declare I understand the requirements of the Data Protection Act 1998 as they relate to the 2009 adult inpatient survey and will conform to these requirements and the guidelines set out under the section “Data protection” in the Guidance Manual for the 2009 adult inpatient survey.

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

SUPPORTING BRIEFING NOTE: ISSUES HIGHLIGHTED BY THE 2009 SURVEY OF PATIENTS IN NHS HOSPITALS IN ENGLAND

This briefing note provides key findings from the seventh national survey of adult acute hospital inpatients. Over 69,000 adult patients from 162 acute and specialist NHS trusts in England responded to the survey between September 2009 and January 2010, a response rate of 52%.

The results from the survey are primarily intended for use by NHS trusts to help improve their performance. The Care Quality Commission will also use them in a range of ways, including setting out national and trust findings; informing patients and the public of trusts' results; and using the results in regulatory activities such as registration, the monitoring of ongoing compliance, and reviews. The Department of Health will also use the results in measuring performance against a range of indicators.

The significance of changes

This briefing note provides the percentage results for England as a whole by aggregating responses from patients for each trust that took part in the survey, then calculating the average across all trusts to form the national results for England. Doing this gives each trust an equal input in the overall result and reflects the experiences of patients in the 'average' English NHS Trust.

The scored results for individual NHS trusts are available on the Care Quality Commission website: **http://www.cqc.org.uk/PatientSurveyInpatient2009**

This briefing note highlights those aspects of care where there have been statistically significant changes from 2008 (the last time the survey was carried out) and 2002 (the first time the survey was carried out).

Some of the changes over time may appear small – often around one percentage point or less - but all reported changes are "statistically significant". This means that we have carried out tests to identify the changes that are unlikely to have occurred by chance.

Where there has been no "statistically significant" change, differences or comparisons are either not mentioned or we clearly state that there has been no change. In some cases we are unable to present comparisons, either because questions are new to the survey in 2009, or because questions from earlier surveys were not asked in 2009.

Key findings summary

This section provides a broad outline of the main survey findings, according to whether they show improvements over the past year in patient experience, a decline, or no significant change.

Improvements since the 2008 survey have been identified in the following areas. Greater proportions of patients said that:

- They waited no more than a month to be admitted to hospital for a planned admission.
- They never shared a sleeping area in hospital (for example a room or bay) with a member of the opposite sex.
- They did not mind sharing a sleeping area with patients of the opposite sex if this happened when they were first admitted.
- They did not use the same bathroom or shower area as a member of the opposite sex.
- Wards, toilets and bathrooms were “very clean”.
- Doctors and nurses “always” washed or cleaned their hands between touching patients.
- They had a lockable place to store their personal belongings.
- There were “always or nearly always” enough nurses on duty to care for them.
- They “definitely” felt involved in decisions about their discharge.
- They received copies of letters between their GP and the hospital.
- The teamwork between doctors and nurses was “excellent”.
- They were asked to give their views about the quality of their care.
- They saw posters and leaflets about how to complain about their care.
- The overall quality of care they received was “excellent”.

Patients’ experiences had deteriorated in several areas since the 2008 survey. Smaller proportions of patients said that:

- They were provided with enough information about their condition or treatment on the ward.
- They were given enough information about their condition or treatment while in the emergency department.
- They were given enough privacy when being examined or treated in the emergency department.
- They were offered a choice of admission date.
- They were **not** bothered by noise at night from staff.
- They rated the hospital food as “good” (although there was no change in the proportion of those rating it as “very good”).
- Their questions were answered by nurses in a way they could understand.
- They “always” had trust and confidence in the nurses treating them.
- Their family or someone else close to them had the opportunity to talk to a doctor if they wanted to.
- Staff “definitely” did enough to control their pain.
- The call button was answered within “0 minutes/right away”.
- The purposes and side effects and how to take their medicines had been “completely” explained to them in a way they could understand.

No significant changes since 2008 were identified in the following areas:

- Waiting times to be admitted from the Emergency Department.
- Patients' reports of the time they waited to be admitted to a bed on a ward after arrival at the hospital.
- Patients' privacy when being examined or treated on the ward and when discussing their condition or treatment on the ward.
- Patients being bothered by noise at night from other patients.
- Patients feeling threatened by other patients or visitors on the ward.
- Patients being offered a choice of food.
- Patients' trust and confidence in doctors.
- Doctors or nurses talking in front of patients as if they were not there.
- Patients being as involved as much as they would like to be in decisions about their care and treatment.
- Patients who required help to eat their meals receiving it.
- A member of staff explained the risks and benefits of an operation or procedure in a way they could understand.
- Patients feeling informed about what would happen during operations or procedures.
- Patients being told how they should expect to feel after their operation or procedure.
- Patients experiencing a delay to their discharge from hospital.
- Provision of written or printed information about what patients should do after leaving hospital.
- Patients wanting to complain about the care they received.

The survey results are discussed in further detail below, examining each element of the patient's journey from admission to their discharge.

Admission to hospital

Respondents were asked whether their most recent admission was planned in advance or an emergency. In the 2009 adult inpatient survey, 55% of respondents said that they had an emergency or urgent admission to hospital, 42% said that they had been on a waiting list or had a planned admission, while three percent reported having a different kind of admission and responded “something else” (for example, they may have been transferred from another hospital). These figures are unchanged from the 2008 survey.

All patients were asked how they felt about the time it took to get a bed on the ward from the time they first arrived at hospital. The majority (69%) did not feel they had to wait a long time, an improvement from 67% in 2002. Eleven percent said they “definitely” felt they had to wait a long time and another 19% felt they waited a long time “to some extent”. These figures do not represent a significant change since the 2008 survey.

Of those who had an emergency or urgent admission or who answered “something else”, 87% said that they went to the Emergency Department when they first arrived at hospital (a decrease of one percentage point since 2008).

The Emergency Department

This section describes the admission experiences of respondents who were admitted to hospital through the Emergency Department.

Information provision

The majority of respondents (73%) said that they were given the ‘right amount’ of information about their condition or treatment while in the emergency department. However, over a quarter of respondents said they were either not given enough information (16%) or were not given any at all (10%), the latter representing a one percentage point increase on the 2008 survey where nine per cent reported not being given any information.

Privacy

There has been a decline in the proportion who said they were “definitely” given enough privacy when being examined or treated in the emergency department; from 76% in 2008 to 75% in 2009. A further 23% said they were given enough privacy “to some extent” (up one percentage point from 22% in 2008) and two percent (unchanged on 2008) said they were not given enough privacy in the Emergency Department.

Waiting times

Patients' reports of waiting times from arrival at the emergency department to being admitted to a bed on a ward have changed significantly since the first national inpatients survey in 2002. The proportion of those **not** having to wait has decreased from 13% in 2002 to seven per cent in 2009 as has the proportion waiting less than an hour, from 26% in 2002 to 22% in 2009. The proportion of those waiting more than four hours has also decreased (from 34% in 2002 to 28% in 2009), although it is unchanged since 2008. There have been corresponding increases in the proportion of patients waiting between one and two hours (from 13% in 2002 to 18% in 2009) and between two and four hours (from 15% in 2002 to 25% in 2009).

The figures show no significant change from the 2008 survey. This year, 72% of patients said they waited four hours or less to be admitted. These figures cannot be directly compared with the national four hour standard for Emergency departments as the adult inpatient survey only covers adults who were admitted as inpatients following their visit, excluding all children and those admitted for maternity or psychiatric reasons.

Planned admissions

This section describes the admission experiences of respondents who were referred to hospital by a healthcare professional and had a planned inpatient stay.

Choice

The 2009 survey asked respondents who had a planned admission whether they were offered a choice of hospitals for their first appointment. Thirty-one percent said they were offered a choice of hospital, ten percent said they were not but would have liked a choice, and the remaining 59% said they were not offered a choice but did not mind. These figures are not comparable with those from the 2008 survey due to a change in the response options[1].

The majority of respondents who had a planned admission were referred to the hospital by a doctor from their local general practice (72%). A quarter (25%) were referred by another doctor or specialist, with small proportions of patients saying they had been referred by a practice nurse or nurse practitioner (one per cent) or by another health professional such as a dentist, optometrist or physiotherapist (two per cent).

Waiting times

Overall, 79% of respondents said they waited four months or less to be admitted from a waiting list for a planned admission, up from the previous year's 77%. This included a significant increase in the proportion stating that they waited “up to 1 month”, which rose from 29% in 2008 to 30% in 2009.

The proportion of patients who felt they were admitted “as soon as they thought was necessary” (76%) was unchanged from 2008, but an improvement from the first adult inpatient survey in 2002, when 68% of

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[1] Respondents were asked “when you were referred to see a specialist, were you offered a choice of hospital for your first hospital appointment”. In the 2008 survey the response options offered to respondents were “Yes”, “No”, or “Don't know/can't remember”. For 2009 the “No” option was replaced with two new options “No, but I would have liked a choice” and “No, but I did not mind” to provide more detailed information around people's experiences of being offered a choice of hospital.

respondents said this. An additional 16% of respondents felt they “should have been admitted a bit sooner”, while eight percent said that they “should have been admitted a lot sooner”.

There has been a decrease in the proportion of patients who said they were given a choice of admission dates, from 30% in 2008 to 29% in 2009. Eighty percent of patients said their admission date was not changed by the hospital, an improvement from 78% in 2002. Seventeen percent said their admission date was changed once, three percent said their appointment had been changed 2 or 3 times and less than one percent said it had been changed four times or more. These figures did not significantly differ from those in the 2008 survey.

Mixed-sex accommodation and bathrooms

The virtual elimination of mixed-sex accommodation is a priority within the NHS Operating Framework for England for 2010/11. This is a complex area to assess using patient experience surveys as patients’ reporting of their experience can be influenced by:

- the purpose of the ward they stay in;
- their journey around the hospital – a third stayed in two or more wards;
- their perceptions of what constitutes mixed-sex accommodation.

To understand some of these effects, the survey results are presented separately for emergency and planned admissions. We distinguish between sharing when the patient was first admitted and after any subsequent moves. The analysis excludes those patients (21% in the 2009 survey) who stayed in critical care and admissions units: whilst there are no exemptions from the need to provide high quality standards of privacy and dignity in these areas, there are more likely to be individual cases where clinical needs take priority.

Planned Admission

The majority (92%) of respondents who had a planned admission to hospital said that they **did not** share a sleeping area (for example a room or bay) with patients of the opposite sex when they were **first admitted** to a bed on a ward, an improvement of two percentage points from 2008. For those respondents who were then **moved to another ward**, 92% said that they **did not** share a sleeping area with patients of the opposite sex. This does not represent a significant change from the 2008 survey but is three percentage points better than in 2006 (the first time this question was asked).

Twenty-seven percent of these elective patients said they minded sharing when **first admitted** but this increased to 40% if they needed to share **after being moved** to another ward. Neither of these results differs significantly from the 2008 findings.

Emergency Admission

Seventy-nine percent of respondents who had an emergency or urgent admission said that they **did not** have to share a sleeping area (for example a room or bay) with patients of the opposite sex when they were **first admitted** to bed on a ward. This is an eight percentage point improvement on the 2008 survey findings (71%). For those respondents who were then **moved to another ward,** 91% percent said they **did not** to share a room or bay with patients of the opposite sex, an improvement of four percentage points from 2008 (87%) and seven percentage points from 2006 (84%).

Thirty-five percent of emergency or urgent patients said they minded sharing when **first admitted** but this increased to 40% if they needed to **share after being moved** to another ward. Neither of these results differs significantly from the 2008 findings.

Bathrooms

Patients should not have to share toilet and washing facilities with the opposite sex, unless they need specialised equipment such as hoists or specialist baths. Twenty three percent of respondents reported having to use the same bathroom or shower area as patients of the opposite sex, an improvement of seven percentage points since the 2008 survey, when 30% reported this experience. Another two percent of patients said they needed to share a bathroom because it had special bathing equipment they needed, a significant decrease of less than one percentage point.

All admissions

From this point on, this document describes the experiences of all respondents except where otherwise stated. That is, responses from both those who had a planned admission and those who were admitted in an emergency are included in the results.

The Hospital and Ward

Noise at night

Although there was no significant change between 2008 and 2009 in the proportion of respondents saying that they were bothered by noise at night from other patients, this has increased steadily, from 37% in 2005 when the question was first asked to 40% in 2009. Around a fifth of respondents (21%) said that they were bothered by noise at night from hospital staff, a significant increase of less than one percentage point from 2008. This figure has been increasing steadily since 2005 when it was 18%.

Cleanliness

Improvements have been made in cleanliness of hospital trusts in the past year, demonstrated by better results for all questions on perceived cleanliness in the 2009 survey.

This year, almost two thirds of respondents (64%) rated their room or ward as “very clean,” up four percentage points since 2008 (60%) and eight percentage points since 2002 (56%). Thirty two percent described their room or ward as “fairly clean”. Three percent of respondents rated their room or ward as “not very clean” (down one percentage point from four per cent in 2008) and one percent said it was “not at all clean” - a significant decrease of less than one percentage point since 2008.

Fifty-seven percent of respondents rated the toilets or bathrooms as “very clean”, up five percentage points since 2008 (52%). Thirty six percent rated the toilets or bathrooms as “fairly clean”. Six percent of respondents rated the toilets and bathrooms as “not very clean” (down one percentage point from 2008) and one percent said they were “not at all clean” (down from two percent in 2008).

Two new questions in the 2009 survey asked about information about and provision of handwash gels to patients and visitors. Ninety-six percent of respondents remembered seeing posters or leaflets asking patients to wash their hands or to use hand-wash gels and 97% of patients said these were available for patients and visitors to use. One percent of respondents said that the hand-wash gel containers were empty and two per cent said that they did not see any hand-wash gels while in hospital.

Security
A minority of respondents (four per cent) felt threatened during their stay in hospital by other patients or visitors, and this is unchanged since the last survey. Thirty-two percent of respondents stated that they had somewhere on the ward to keep their personal belongings and could lock it if they wanted to, up one percentage point since 2008. Four percent of respondents reported that they had nowhere to keep their personal belongings, unchanged from last year. The remaining 63% of respondents said that they did have somewhere to store belongings but no way to lock it, down two percentage points from 2008.

Quality of food
Of those respondents who had hospital food, a fifth (20%) rated it as “very good,” no change from 2008 but an increase from 18% in 2002. Just over a third (35%) described the food as “good”, a decrease of one percentage point since 2008; 30% of respondents thought it was “fair”. There has been a statistically significant increase, of less than one percentage point, from 2008 in the proportion of respondents who rated the food as poor (14%).

Overall, 78% of respondents reported that they were “always” offered a choice of food, no change from the previous survey, while another 16% said they were offered a choice “sometimes”. Six percent of respondents said they were not offered a choice of food. However, this question showed differences related to how long respondents had been in hospital for: 13% of respondents who only stayed overnight said they were not offered a choice of food compared with four percent of those who stayed more than one night.

Doctors and nurses

Confidence and trust

Four fifths (80%) of respondents reported “always” having confidence and trust in the doctors treating them and a further 17% reported “sometimes” having this. Three percent said they did not have confidence and trust in the doctors treating them. Results for this question were not significantly different from those in 2008 or earlier surveys.

The proportion of respondents reporting that they “always” had confidence in the nurses treating them fell by one percentage point from 75% in 2008 to 74% in 2009, while those reporting that they “sometimes” had this increased one percentage point to 23%. Three percent said they did not have confidence and trust in the nurses treating them, which was unchanged from 2008.

Information and answers to questions

Sixty-seven percent of respondents stated that doctors “always” answered their questions in a way they could understand, no change from 2008, though an improvement from 65% in 2002. A further 27% said they “sometimes” got answers they could understand, and six per cent said that they did not get answers they were able to understand, unchanged from 2008.

For nurses, 65% said that nurses ‘always’ answered their questions in a way they could understand, a decrease from 66% in 2008, though an improvement on 63% in 2002. There was a corresponding increase in the proportion who said nurses “sometimes” gave them answers that they could understand - from 29% in 2008 to 30% in 2009. The remainder (five per cent) said they did not receive answers they were able to understand.

Patients were asked whether one member of staff ever told them one thing and another told them something quite different. The majority of respondents (65%) said that staff did not give them conflicting information. Eight percent of patients said staff “often” gave them conflicting information and another 27% said this occurred “sometimes”; this is unchanged from the 2008 survey.

Staff acknowledging patients

Patients were asked whether staff talked in front of them “as if they were not there.”

The majority of respondents (72%) said that doctors did not talk in front of them as if they were not there: this was unchanged from 2008 but an improvement from 71% in 2002. Six percent of respondents said this happened “often” and another 22% said it happened “sometimes”.

The majority (78%) said that nurses did not talk in from of them as if they were not there: again, this was unchanged from 2008 but a decrease from 2002 where 81% said that nurses did not talk in from of them as if they were not there. Five percent said this occurred “often” and another 17% said it happened “sometimes”. There have been no statistically significant changes in these figures since the 2008 survey.

Handwashing

Washing and cleaning hands after contact with patients is essential to control the spread of infection within hospitals. There has been an increase in the proportion of patients reporting that, as far as they knew, doctors and nurses “always” washed or cleaned their hands between patients.

When asked if doctors washed or cleaned their hands between touching patients, 76% of respondents replied that, as far as they knew, this was “always” the case, up two percentage points since 2008 (74%) and nine percentage points since 2005 (67%), when the question was first asked. Only seven per cent of respondents said that doctors did not wash or otherwise clean their hands between touching patients, down from eight per cent in 2008 and 12% in 2005.

When asked the same question with regards to nurses, of those respondents who could remember, 79% replied that as far as they knew, nurses “always” cleaned their hands between patients, up from 76% in 2008 and 69% in 2005. Four percent of respondents said that nurses did not wash or clean their hands, a statistically significant decrease of less than one percentage point since the 2008 survey and down from seven per cent in 2005.

Availability of staff

Fifty-nine percent of respondents said they thought there were “always or nearly always” enough nurses on duty to care for them while they were in hospital, up from 58% in 2008. Another 30% said there were “sometimes” enough nurses, down from 31% in 2008. Ten percent said there were “rarely or never enough nurses”.

Twenty-two percent of respondents reported that they could not find someone on the hospital staff to talk to about their worries or fears - this was unchanged since the 2008 survey but higher than in 2002 (17%). Forty-one percent said they were “definitely” able to find someone and 38% said they were able to “to some extent”.

Patient care and treatment

Involvement in decisions

Providing the right amount of information to each patient in an understandable way is essential for them to be able to make informed decisions about their care and treatment. The majority of respondents (78%) said that they were given the “right amount” of information about their care and treatment, no change from the 2008 survey. Just over a fifth of respondents (21%) reported that they had not been given enough information about their condition or treatment (a statistically significant increase of less than one percentage point since the 2008 survey) while one percent said they had been given “too much" information (a statistically significant decrease of less than one percentage point since 2008).

About half of respondents (52%) felt that they were "definitely" as involved as they wanted to be in decisions about their care and treatment. Thirty-seven percent felt this "to some extent" and 11% were not as involved as much as they would have liked to be. There has been no change in these results compared with the 2008 survey.

Of those respondents whose family or someone else close to them wanted to talk to a doctor, 42% reported that they "definitely" had enough opportunity to do so, a decrease of two percentage points from the 2008 survey results (44%). The proportion of those who said that their family or someone else close to them did not have the opportunity to talk with a doctor increased one percentage point from 16% in 2008 to 17% in 2009 and the proportion who felt this was the case "to some extent" was 40%, showing no change from the previous survey but a two percentage point change from 2002 (38%).

Pain management

Sixty-seven percent of patients said they were in pain at some point during their hospital stay, unchanged from 2008. There has been a decrease in the proportion of respondents saying that staff "definitely" did enough to help control their pain (71%), compared with 72% in 2008 and 2002. Twenty-three percent of respondents said that this was the case "to some extent" although six percent said staff did not do everything they could have to control their pain (unchanged from 2008).

Privacy

The proportion of respondents saying that they were "always" given enough privacy when discussing their condition or treatment was 70%, unchanged from 2008 but two percentage points higher than in 2002 (68%). A further 22% said they were "sometimes" given enough privacy and eight percent said they were not given enough privacy.

Eighty-eight percent of respondents said that they were "always" given enough privacy when being examined or treated and another ten percent said this happened "sometimes", with two per cent saying they were not given enough privacy. There has been no change in these results since 2008.

Calling for help using a call button

There has been very little change since 2008 in how quickly call buttons were usually answered, although there has been a one percentage point decrease in the proportion of respondents who said they were normally answered "right away", from 17% in 2008 to 16% in 2009. Thirty-eight percent of respondents said it was answered in 1-2 minutes, 29% said between 3-5 minutes, 15% said more than five minutes and two percent said they never got help when they used the call button.

Help with eating

Just under a fifth (18%) of respondents said that they did not get enough help from hospital staff to eat their meals if they needed it, unchanged from 2008. Just under two thirds (63%) "always" received enough help, no change from 2008 but an improvement from 58% in 2002. The remainder (19%) "sometimes" received enough help.

Operations and procedures

As in the 2008 survey, 67% of respondents said that they had an operation or procedure during their hospital stay.

Before the operation or procedure

Eighty-one percent of respondents said that they were "completely" informed about the risks and benefits of the operation or procedure in a way they could understand, and another 15% said that they had been informed "to some extent". Only three per cent said that they were not informed. Nearly three-quarters of respondents (74%) reported that staff "completely" explained what would be done during the operation or procedure and 21% said that this was explained "to some extent". This was an improvement of less than one percentage point from the 2008 survey and the only statistically significant change for all questions about operations and procedures. The remaining five per cent said that a member of staff did not explain what would be done during the operation or procedure.

Seventy-six percent said that a member of staff had "completely" answered their questions about the operation or procedure while 20% said that they were answered "to some extent" and three per cent said they were not. Fifty-six percent felt that they were "completely" informed about how they could expect to feel after the operation or procedure, 28% that they were informed "to some extent" and 15% that they were not informed.

Eight-six percent of respondents said they were given an anaesthetic or pain relief medication before the operation or procedure. Of these, 84% reported that they were given an explanation of how this would be done that they "completely" understood and 12% said they were told "to some extent". The remaining four per cent said that they were not given an understandable explanation of how any anaesthetic of pain relief would be administered.

After the operation or procedure

Sixty four percent of respondents who had an operation or procedure said they were "completely" told how their operation or procedure had gone in a way they could understand, 24% said this happened "to some extent" and 12% percent said that they did not receive this information.

Leaving hospital

Good provision of information is crucial for patients to manage their ongoing care, and the 2009 figures show progress on this during the past year.

There was an overall increase in the proportion of patients who “definitely” felt involved in decisions about their discharge from hospital – up from 53% in 2007 (when the question was first asked) to 54% in 2008 and 55% in 2009. Sixteen percent of respondents reported not feeling involved in discharge decisions, a statistically significant decrease of less than one percent from the 2008 survey. The remaining 30% felt involved “to some extent” in decisions about their discharge from hospital.

Waiting for discharge from hospital

Whilst the majority of patients reported that there was no delay to their discharge from hospital (60%), the proportion of respondents who said that their discharge was delayed is unchanged from 2008, remaining at 40%. As in the previous survey, the most common reason given for a delay was waiting for medicines (61%). The second most commonly cited reason was waiting to see the doctor (16%) and nine percent said they had to wait for an ambulance. Fourteen percent of respondents stated that they were delayed due to “something else”.

There have been no statistically significant changes since the 2008 survey in the length of delay to discharge with 16% saying they were delayed by up to one hour, 29% saying it was longer than one, but less than two hours, 32% waiting from two to four hours and 22% waiting longer than four hours.

Medication

Three quarters (75%) of respondents who had medication to take home said that they were told “completely” about the purpose of the medication, down one percentage point from 2008 (76%) and four percentage points since 2002 (79%). Nine percent said that they were not told the purpose of their medication, up from eight percent in 2008 and seven percent in 2002. The remaining 16% were told “to some extent”. With regard to medication side effects to watch out for, 36% of patients said they were told “completely” about what to look out for, down two percentage points since the 2008 survey (38%) and three percentage points since 2002 (39%). The proportion who said they were not told about the side effects increased from 44% in 2008 to 45% in 2009. The remaining 18% were told “to some extent”.

Seventy-five percent of respondents said they were “definitely” told how to take their medications in a way they could understand (down from 76% in 2008) and the proportion who said they were not told increased from nine percent in 2008 to ten percent in 2009. The remainder (15%) said that they were “told to some extent”.

The proportion of respondents who said they were given clear written or printed information about their medicines showed no statistically significant change from 2008. Two thirds (66%) of respondents felt that this was "completely" the case, while 16% felt they received clear written or printed information about their medicines "to some extent". Just under a fifth (18%) said that they were not given any information.

Information at discharge

Sixty-three percent of respondents said they were given written or printed information about what they should or should not do after leaving hospital, unchanged from 2008. The remaining 37% said that they were not given this information.

Thirty-nine percent of respondents said they were told "completely" about any danger signs to watch for after they went home, and another 21% said they were told about this "to some extent". Two fifths (40%) said that they were not told what danger signals to watch for after they went home. Three quarters (75%) said that hospital staff told them who to contact if they were worried about their condition, with a quarter (25%) saying they were not given this information, no change from previous years. The proportions of those who reported that doctors or nurses "definitely" gave their family or someone close to them all the information they needed to care for them was also unchanged from previous years at 44%, with a further 23% saying this happened "to some extent" and 33% saying that this did not happen.

Copies of letters

Department of Health guidance states that patients should receive copies of letters sent between clinicians. Although, as with last year, the majority of respondents did not receive copies of letters sent between hospital doctors and the patient's GP (53% in 2009, down from 57% in 2008), the proportion of those who did has improved from 35% in 2005 when the question was first asked, to 43% in 2008 and 47% in 2009. Seventy-three percent of those who received copies of letters thought they were "always" written in a way they could understand, although four percent said that they were not understandable. The remainder (24%) said that the letters were "sometimes" written in a way they could understand.

Overall care

The percentage of respondents rating their overall care as "excellent" has increased every year since the adult inpatient survey began, from 38% in 2002, to 43% in 2008 and 44% in 2009. Thirty-five percent rated their care as "very good" (although this has decreased by less than one percentage point since 2008), 13% rated it as "good", five percent rated it as "fair", and two percent as "poor".

The proportion of patients who rated the teamwork of doctors and nurses as "excellent" increased from 39% in 2008 to 41% this year. However, the proportion of respondents who rated the teamwork as "very good" fell correspondingly by two percentage points from 39% in 2008 to 37%. The proportion of patients rating teamwork as "excellent", "very good" or "good" remains unchanged from 2008 at 92%. Only seven per cent rated teamwork as either "fair" (five per cent) or "poor" (two per cent).

Respect and dignity
Seventy-nine percent of respondents said they felt they were “always” treated with respect and dignity and another 18% felt this was “sometimes” the case. Three percent said they did not feel they were treated with respect and dignity. There has been no change to the results of this question compared with the 2008 survey.

Complaints
In 2009, ten percent of patients reported that they were asked to give their views on the quality of their care during their stay, up from six percent in 2005 and nine percent in 2008. Forty-one percent of respondents remembered seeing posters or leaflets explaining how to complain about the care they received in hospital (up three percentage points from 38% in 2008) and eight percent of respondents said they wanted to complain about the care they received, unchanged since 2008.

Notes on the survey

The 2009 adult inpatients survey involved 162 acute NHS trusts in England. The sample was taken from patients discharged from hospital in June, July or August 2009. The survey fieldwork was carried out between September 2009 and January 2010. Patients were eligible for the survey if they were 16 years or older, had at least one overnight stay, and were not under the care of a consultant from maternity or psychiatric specialties. We received responses from over 69,000 patients, a response rate of 52%. Note that not all percentage totals will add up to 100, due to rounding.

Five acute trusts did not participate in the survey as they were not eligible for inclusion – either because they do not treat adults or because they have insufficient numbers of inpatients.

A report for each participating trust is available on the Care Quality Commission website. These reports show how each trust performed for every question that measures the quality of patient experience. The results for each trust are compared against all other trusts which took part. Since the types of patients at each hospital trust can differ, these reports are standardised for age, gender and the route of admission to hospital for each respondent. This allows trusts, and others, to compare performance, identify areas where they are currently performing well and to show where improvement is needed.
`http://www.cqc.org.uk/PatientSurveyInpatient2009`

The results for each trust will also be available under the organisation search tool of the CQC website:

http://healthdirectory.cqc.org.uk
(Select “summary information”, enter a postcode or organisation name, then scroll down to ‘`What patients said about this trust`’)