Emergency Department Questionnaire

What is the survey about?

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

Who should complete the questionnaire?

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

Completing the questionnaire

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

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

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

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

Questions or help?

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

Your participation in this survey is voluntary.

Your answers will be treated in confidence.

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

A. ARRIVAL AT THE EMERGENCY DEPARTMENT

A1. How did you travel to the hospital?

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

B. WAITING

First assessment (Triage)

B1. Following your arrival in the Emergency Department, how long did you wait for **a nurse to assess your priority** (i.e. how long did you wait to see a triage nurse)?

1 ☐ I did not have to wait to be assessed ➔ **Go to B2**
2 ☐ 1 - 15 minutes ➔ **Go to B2**
3 ☐ 16 - 30 minutes ➔ **Go to B2**
4 ☐ 31 – 60 minutes ➔ **Go to B2**
5 ☐ More than 60 minutes ➔ **Go to B2**
6 ☐ Don't know/ Can't remember ➔ **Go to B2**
7 ☐ I left before I was assessed ➔ **Go to C1**

B2. Were you told what priority level you had been given?

1 ☐ Yes, I was Category 1 - **Immediate** (Red)
2 ☐ Yes, I was Category 2 - **Very urgent** (Orange)
3 ☐ Yes, I was Category 3 - **Urgent** (Yellow)
4 ☐ Yes, I was Category 4 - **Standard** (Green)
5 ☐ Yes, I was Category 5 - **Non-urgent** (Blue)
6 ☐ No, I was not told my priority
7 ☐ It was not necessary because I was seen straight away
8 ☐ Don't know/ Can't remember

B3. Overall, did you think the patient priority system was fair?

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

Waiting to see a doctor or nurse practitioner

B4. Following your arrival in the Emergency Department, how long did you wait **before being examined** by a doctor or nurse practitioner?

1 ☐ I did not have to wait ➔ **Go to B6**
2 ☐ 1 - 30 minutes ➔ **Go to B5**
3 ☐ 31 - 60 minutes ➔ **Go to B5**
4 ☐ More than 1 hour but no more than 2 hours ➔ **Go to B5**
5 ☐ More than 2 hours but no more than 4 hours ➔ **Go to B5**
6 ☐ More than 4 hours ➔ **Go to B5**
7 ☐ Can't remember ➔ **Go to B5**
8 ☐ I did not see a doctor or a nurse practitioner ➔ **Go to B6**

B5. Were you told **how long** you would have to wait to be examined?

1 ☐ Yes, but the wait was **shorter**

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

3 ☐ Yes, but the wait was **longer**

4 ☐ No, I was not told

5 ☐ Don't know/ Can't remember

B6. Overall, how long did your visit to the Emergency Department last?

1 ☐ Up to 1 hour

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

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

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

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

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

7 ☐ More than 24 hours

8 ☐ Can't remember

C. DOCTORS AND NURSES

C1. Did you have **enough time** to discuss your health or medical problem with the doctor or nurse?

1 ☐ Yes, definitely ➔ **Go to C2**

2 ☐ Yes, to some extent ➔ **Go to C2**

3 ☐ No ➔ **Go to C2**

4 ☐ I did not see a doctor or a nurse ➔ **Go to D1**

C2. While you were in the Emergency Department, did a doctor or nurse explain your condition and treatment in a way you could understand?

1 ☐ Yes, completely

2 ☐ Yes, to some extent

3 ☐ No

4 ☐ I did not need an explanation

C3. Did the doctors and nurses listen to what you had to say?

1 ☐ Yes, definitely

2 ☐ Yes, to some extent

3 ☐ No

C4. Did you think that doctors or nurses were deliberately not telling you certain things that you wanted to know?

1 ☐ Yes, definitely

2 ☐ Yes, to some extent

3 ☐ No

C5. If you had any anxieties or fears about your condition or treatment, did a doctor or nurse discuss them with you?

1 ☐ Yes, completely

2 ☐ Yes, to some extent

3 ☐ No

4 ☐ I didn't have anxieties or fears

C6. Did you have confidence and trust in the doctors and nurses examining and treating you?

1 ☐ Yes, definitely

2 ☐ Yes, to some extent

3 ☐ No

C7. In your opinion, did the doctors and nurses in the Emergency Department know enough about your condition or treatment?

1 ☐ All of them knew enough

2 ☐ Most of them knew enough

3 ☐ Only some of them knew enough

4 ☐ None of them knew enough

5 ☐ Don't know/ Can't say

C8. Did doctors or nurses talk in front of you as if you weren't there?

1 ☐ Yes, definitely

2 ☐ Yes, to some extent

3 ☐ No

D. YOUR CARE AND TREATMENT

D1. Do you need any help understanding English?

1 ☐ Yes ➔ **Go to D2**

2 ☐ No ➔ **Go to D3**

D2. When you were in the Emergency Department, was there someone who could interpret for you?

1 ☐ Yes, a relative or friend

2 ☐ Yes, an interpreter from the hospital

3 ☐ Yes, someone else on the hospital staff

4 ☐ No

D3. While you were in the Emergency Department, how much information about your condition or treatment was given to **you**?

1 ☐ Not enough

2 ☐ Right amount

3 ☐ Too much

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

D4. Were you given enough privacy when **discussing your condition or treatment?**

1 ☐ Yes, definitely

2 ☐ Yes, to some extent

3 ☐ No

D5. Were you given enough privacy when **being examined or treated**?

1 ☐ Yes, definitely

2 ☐ Yes, to some extent

3 ☐ No

D6. Sometimes in a hospital, a member of staff will say one thing and another will say something quite different. Did this happen to you in the Emergency Department?

1 ☐ Yes, definitely

2 ☐ Yes, to some extent

3 ☐ No

D7. Were you involved as much as you wanted to be in decisions about your care and treatment?

1 ☐ Yes, definitely

2 ☐ Yes, to some extent

3 ☐ No

4 ☐ I was not well enough to be involved in decisions about my care

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

E1. Did you have any tests (such as x-rays, ultrasounds or scans) when you visited the Emergency Department?

1 ☐ Yes ➔ **Go to E2**

2 ☐ No ➔ **Go to F1**

E2. How long did you wait **for your tests to be carried out**?

1 ☐ I did not have to wait
2 ☐ 1 - 15 minutes
3 ☐ 16 - 30 minutes
4 ☐ 31 - 60 minutes
5 ☐ More than 1 hour but no more than 2 hours
6 ☐ More than 2 hours but no more than 4 hours
7 ☐ More than 4 hours
8 ☐ Can't remember

E3. Did a member of staff explain the **results of the tests** in a way you could understand?

1 ☐ Yes, definitely
2 ☐ Yes, to some extent
3 ☐ No
4 ☐ Not sure/ Can't remember
5 ☐ I was told that the results of the tests would be given to me at a later date
6 ☐ I was never told the results of the tests

F. PAIN

F1. Were you in any pain while you were in the Emergency Department?

1 ☐ Yes ➔ **Go to F2**
2 ☐ No ➔ **Go to G1**

F2. Whilst you were in the Emergency Department, how much of the time were you in pain?

1 ☐ All or most of the time
2 ☐ Some of the time
3 ☐ Occasionally

F3. Did you request pain medicine?

1 ☐ Yes ➔ **Go to F4**
2 ☐ No ➔ **Go to F5**

F4. How many minutes after you requested pain medicine did it take before you got it?

1 ☐ 0 minutes/right away
2 ☐ 1 - 5 minutes
3 ☐ 6 - 10 minutes
4 ☐ 11 - 15 minutes
5 ☐ 16 - 30 minutes
6 ☐ More than 30 minutes
7 ☐ I asked for pain medicine but wasn't given any

F5. Do you think the hospital staff did everything they could to help control your pain?

1 ☐ Yes, definitely
2 ☐ Yes, to some extent
3 ☐ No
4 ☐ Can't say/ Don't know

G. HOSPITAL ENVIRONMENT AND FACILITIES

G1. In your opinion, how clean was the Emergency Department?

1 ☐ Very clean
2 ☐ Fairly clean
3 ☐ Not very clean
4 ☐ Not at all clean
5 ☐ Can't say

G2. How clean were the toilets in the Emergency Department?

1 ☐ Very clean

2 ☐ Fairly clean

3 ☐ Not very clean

4 ☐ Not at all clean

5 ☐ I did not use a toilet

G3. While you were in the Emergency Department, did you feel bothered or threatened by other patients?

1 ☐ Yes, definitely

2 ☐ Yes, to some extent

3 ☐ No

H. LEAVING THE EMERGENCY DEPARTMENT

H1. What happened at the end of your visit to the Emergency Department?

1 ☐ I was admitted to the same hospital as an inpatient ➔ **Go to H2**

2 ☐ I was transferred to a different hospital or nursing home ➔ **Go to H2**

3 ☐ I went home ➔ **Go to H3**

4 ☐ I went to stay with a friend or relative ➔ **Go to H3**

5 ☐ I went to stay somewhere else ➔ **Go to H3**

H2. How long did you wait to get to your room or ward and bed?

1 ☐ Up to 1 hour

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

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

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

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

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

7 ☐ More than 24 hours

8 ☐ Can't remember

If you were ADMITTED TO HOSPITAL at the end of your visit to the Emergency Department, now skip to Section J:OVERALL. If you were NOT admitted to hospital, please answer the following questions.

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

H3. Before you left the Emergency Department, were any new medications prescribed or ordered for you?

1 ☐ Yes ➔ **Go to H4**

2 ☐ No ➔ **Go to H6**

H4. Did a member of staff explain **the purpose** of the medications you were to take at home in a way you could understand?

1 ☐ Yes, completely

2 ☐ Yes, to some extent

3 ☐ No

4 ☐ I did not need an explanation

H5. Did a member of staff tell you about **medication side effects** to watch for?

1 ☐ Yes, completely

2 ☐ Yes, to some extent

3 ☐ No

4 ☐ I did not need this type of information

Information

H6. Did a member of staff tell you about what **danger signals** regarding your illness or treatment to watch for after you went home?

1 ☐ Yes, completely

2 ☐ Yes, to some extent

3 ☐ No

4 ☐ I did not need this type of information

H7. Did hospital staff tell you **who to contact** after you got home if you were worried about your condition or treatment?

1 ☐ Yes, they told me to contact **my GP**

2 ☐ Yes, they told me to contact the **practice nurse** at my local health centre

3 ☐ Yes, they told me to contact **NHS Direct**

4 ☐ Yes, I was told to **dial 999**

5 ☐ Yes, they told me to return to the **hospital**

6 ☐ Yes, I was told to contact **someone else**

7 ☐ No, I was not told who to contact

8 ☐ I did not need this type of information

9 ☐ Don't know/ Can't remember

ALL PATIENTS, please answer the following questions.

J. OVERALL

J1. Overall, did you feel you were treated with respect and dignity while you were in the Emergency Department?

1 ☐ Yes, all of the time

2 ☐ Yes, some of the time

3 ☐ No

J2. Overall, how would you rate the care you received in the Emergency Department?

1 ☐ Excellent

2 ☐ Very good

3 ☐ Good

4 ☐ Fair

5 ☐ Poor

6 ☐ Very poor

K. ABOUT YOU

K1. Are you male or female?

1 ☐ Male

2 ☐ Female

K2. How old are you?

1 ☐ 16 - 35 years

2 ☐ 36 - 50 years

3 ☐ 51 - 65 years

4 ☐ 66 - 80 years

5 ☐ 81 years or older

K3. How old were you when you left full-time education?

1 ☐ 16 years or less

2 ☐ 17 or 18 years

3 ☐ 19 years or over

4 ☐ Still in full-time education

K4. Overall, how would you rate your health during the **past 4 weeks**?

1 ☐ Excellent

2 ☐ Very good

3 ☐ Good

4 ☐ Fair

5 ☐ Poor

6 ☐ Very poor

K5. 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)

L. ANY OTHER COMMENTS

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

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

Was there anything that could have been improved?

Any other comments?

THANK YOU VERY MUCH FOR YOUR HELP

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

Please post this questionnaire back in the FREEPOST envelope provided.

No stamp is needed.

This copy of the emergency department questionnaire indicates how the response options to each evaluative question were scored by the CHI for the calculation of performance scores.

The scores for each response option are noted in the left-hand margin; response options which were not scored are marked as 'M' (treated as missing data).

Emergency Department Questionnaire

What is the survey about?

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

Who should complete the questionnaire?

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

Completing the questionnaire

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

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

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

Questions or help?

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

Your participation in this survey is voluntary.

Your answers will be treated in confidence.

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

A. ARRIVAL AT THE EMERGENCY DEPARTMENT

A1. How did you travel to the hospital?

1 ☐ In an ambulance

2 ☐ By car

3 ☐ By taxi

4 ☐ On foot

5 ☐ On public transport

6 ☐ Other

(this question was not scored)

B. WAITING

First assessment (Triage)

B1. Following your arrival in the Emergency Department, how long did you wait for **a nurse to assess your priority** (i.e. how long did you wait to see a triage nurse)?

100 1 ☐ I did not have to wait to be assessed ➔ **Go to B2**

75 2 ☐ 1 - 15 minutes ➔ **Go to B2**

50 3 ☐ 16 - 30 minutes ➔ **Go to B2**

25 4 ☐ 31 – 60 minutes ➔ **Go to B2**

0 5 ☐ More than 60 minutes ➔ **Go to B2**

M 6 ☐ Don't know/ Can't remember ➔ **Go to B2**

0 7 ☐ I left before I was assessed ➔ **Go to C1**

B2. Were you told what priority level you had been given?

100 1 ☐ Yes, I was Category 1 - **Immediate** (Red)

100 2 ☐ Yes, I was Category 2 - **Very urgent** (Orange)

100 3 ☐ Yes, I was Category 3 - **Urgent** (Yellow)

100 4 ☐ Yes, I was Category 4 - **Standard** (Green)

100 5 ☐ Yes, I was Category 5 - **Non-urgent** (Blue)

0 6 ☐ No, I was not told my priority

100 7 ☐ It was not necessary because I was seen straight away

M 8 ☐ Don't know/ Can't remember

B3. Overall, did you think the patient priority system was fair?

100 1 ☐ Yes

0 2 ☐ No

M 3 ☐ Can't say/ Don't know

Waiting to see a doctor or nurse practitioner

B4. Following your arrival in the Emergency Department, how long did you wait **before being examined** by a doctor or nurse practitioner?

100 1 ☐ I did not have to wait ➔ **Go to B6**

80 2 ☐ 1 - 30 minutes ➔ **Go to B5**

60 3 ☐ 31 - 60 minutes ➔ **Go to B5**

40 4 ☐ More than 1 hour but no more than 2 hours ➔ **Go to B5**

20 5 ☐ More than 2 hours but no more than 4 hours ➔ **Go to B5**

0 6 ☐ More than 4 hours ➔ **Go to B5**

M 7 ☐ Can't remember ➔ **Go to B5**

M 8 ☐ I did not see a doctor or a nurse practitioner ➔ **Go to B6**

B5. Were you told **how long** you would have to wait to be examined?

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

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

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

0 4 ☐ No, I was not told

M 5 ☐ Don't know/ Can't remember

B6. Overall, how long did your visit to the Emergency Department last?

100 1 ☐ Up to 1 hour

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

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

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

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

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

0 7 ☐ More than 24 hours

M 8 ☐ Can't remember

C. DOCTORS AND NURSES

C1. Did you have **enough time** to discuss your health or medical problem with the doctor or nurse?

100 1 ☐ Yes, definitely ➔ **Go to C2**

50 2 ☐ Yes, to some extent ➔ **Go to C2**

0 3 ☐ No ➔ **Go to C2**

M 4 ☐ I did not see a doctor or a nurse ➔ **Go to D1**

C2. While you were in the Emergency Department, did a doctor or nurse explain your condition and treatment in a way you could understand?

100 1 ☐ Yes, completely

50 2 ☐ Yes, to some extent

0 3 ☐ No

M 4 ☐ I did not need an explanation

C3. Did the doctors and nurses listen to what you had to say?

100 1 ☐ Yes, definitely

50 2 ☐ Yes, to some extent

0 3 ☐ No

C4. Did you think that doctors or nurses were deliberately not telling you certain things that you wanted to know?

0 1 ☐ Yes, definitely

50 2 ☐ Yes, to some extent

100 3 ☐ No

C5. If you had any anxieties or fears about your condition or treatment, did a doctor or nurse discuss them with you?

100 1 ☐ Yes, completely

50 2 ☐ Yes, to some extent

0 3 ☐ No

M 4 ☐ I didn't have anxieties or fears

C6. Did you have confidence and trust in the doctors and nurses examining and treating you?

100 1 ☐ Yes, definitely

50 2 ☐ Yes, to some extent

0 3 ☐ No

C7. In your opinion, did the doctors and nurses in the Emergency Department know enough about your condition or treatment?

100 1 ☐ All of them knew enough

67 2 ☐ Most of them knew enough

33 3 ☐ Only some of them knew enough

0 4 ☐ None of them knew enough

M 5 ☐ Don't know/ Can't say

C8. Did doctors or nurses talk in front of you as if you weren't there?

0 1 ☐ Yes, definitely

50 2 ☐ Yes, to some extent

100 3 ☐ No

D. YOUR CARE AND TREATMENT

D1. Do you need any help understanding English?

1 ☐ Yes ➔ **Go to D2**

2 ☐ No ➔ **Go to D3**

(this question was not scored)

D2. When you were in the Emergency Department, was there someone who could interpret for you?

1 ☐ Yes, a relative or friend

2 ☐ Yes, an interpreter from the hospital

3 ☐ Yes, someone else on the hospital staff

4 ☐ No

(this question was not scored)

D3. While you were in the Emergency 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

D4. Were you given enough privacy when **discussing your condition or treatment?**

100 1 ☐ Yes, definitely

50 2 ☐ Yes, to some extent

0 3 ☐ No

D5. Were you given enough privacy when **being examined or treated**?

100 1 ☐ Yes, definitely

50 2 ☐ Yes, to some extent

0 3 ☐ No

D6. Sometimes in a hospital, a member of staff will say one thing and another will say something quite different. Did this happen to you in the Emergency Department?

0 1 ☐ Yes, definitely

50 2 ☐ Yes, to some extent

100 3 ☐ No

D7. Were you involved as much as you wanted to be in decisions about your care and treatment?

100 1 ☐ Yes, definitely

50 2 ☐ Yes, to some extent

0 3 ☐ No

M 4 ☐ I was not well enough to be involved in decisions about my care

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

E1. Did you have any tests (such as x-rays, ultrasounds or scans) when you visited the Emergency Department?

1 ☐ Yes ➔ **Go to E2**

2 ☐ No ➔ **Go to F1**

(this question was not scored)

E2. How long did you wait **for your tests to be carried out**?

100 1 ☐ I did not have to wait

83 2 ☐ 1 - 15 minutes

67 3 ☐ 16 - 30 minutes

50 4 ☐ 31 - 60 minutes

33 5 ☐ More than 1 hour but no more than 2 hours

17 6 ☐ More than 2 hours but no more than 4 hours

0 7 ☐ More than 4 hours

M 8 ☐ Can't remember

E3. Did a member of staff explain the **results of the tests** in a way you could understand?

100 1 ☐ Yes, definitely

50 2 ☐ Yes, to some extent

0 3 ☐ No

M 4 ☐ Not sure/ Can't remember

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

0 6 ☐ I was never told the results of the tests

F. PAIN

F1. Were you in any pain while you were in the Emergency Department?

1 ☐ Yes ➔ **Go to F2**

2 ☐ No ➔ **Go to G1**

(this question was not scored)

F2. Whilst you were in the Emergency Department, how much of the time were you in pain?

0 1 ☐ All or most of the time

50 2 ☐ Some of the time

100 3 ☐ Occasionally

F3. Did you request pain medicine?

1 ☐ Yes ➔ **Go to F4**

2 ☐ No ➔ **Go to F5**

(this question was not scored)

F4. How many minutes after you requested pain medicine did it take before you got it?

100 1 ☐ 0 minutes/right away

83 2 ☐ 1 - 5 minutes

67 3 ☐ 6 - 10 minutes

50 4 ☐ 11 - 15 minutes

33 5 ☐ 16 - 30 minutes

17 6 ☐ More than 30 minutes

0 7 ☐ I asked for pain medicine but wasn't given any

F5. 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

M 4 ☐ Can't say/ Don't know

G. HOSPITAL ENVIRONMENT AND FACILITIES

G1. In your opinion, how clean was the Emergency Department?

100 1 ☐ Very clean

67 2 ☐ Fairly clean

33 3 ☐ Not very clean

0 4 ☐ Not at all clean

M 5 ☐ Can't say

G2. How clean were the toilets in the Emergency Department?

100 1 ☐ Very clean

67 2 ☐ Fairly clean

33 3 ☐ Not very clean

0 4 ☐ Not at all clean

M 5 ☐ I did not use a toilet

G3. While you were in the Emergency Department, did you feel bothered or threatened by other patients?

0 1 ☐ Yes, definitely

50 2 ☐ Yes, to some extent

100 3 ☐ No

H. LEAVING THE EMERGENCY DEPARTMENT

H1. What happened at the end of your visit to the Emergency Department?

1 ☐ I was admitted to the same hospital as an inpatient ➔ **Go to H2**

2 ☐ I was transferred to a different hospital or nursing home ➔ **Go to H2**

3 ☐ I went home ➔ **Go to H3**

4 ☐ I went to stay with a friend or relative ➔ **Go to H3**

5 ☐ I went to stay somewhere else ➔ **Go to H3**

(this question was not scored)

H2. How long did you wait to get to your room or ward and bed?

100 1 ☐ Up to 1 hour

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

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

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

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

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

0 7 ☐ More than 24 hours

M 8 ☐ Can't remember

If you were ADMITTED TO HOSPITAL at the end of your visit to the Emergency Department, now skip to Section K:OVERALL. If you were NOT admitted to hospital, please answer the following questions.

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

H3. Before you left the Emergency Department, were any new medications prescribed or ordered for you?

1 ☐ Yes ➔ **Go to H4**

2 ☐ No ➔ **Go to H6**

(this question was not scored)

H4. Did a member of staff explain **the purpose** of the medications you were to take at home in a way you could understand?

100 1 ☐ Yes, completely

50 2 ☐ Yes, to some extent

0 3 ☐ No

M 4 ☐ I did not need an explanation

H5. Did a member of staff tell you about **medication side effects** to watch for?

100 1 ☐ Yes, completely

50 2 ☐ Yes, to some extent

0 3 ☐ No

M 4 ☐ I did not need this type of information

Information

H6. Did a member of staff tell you about what **danger signals** regarding your illness or treatment to watch for after you went home?

100 1 ☐ Yes, completely

50 2 ☐ Yes, to some extent

0 3 ☐ No

M 4 ☐ I did not need this type of information

H7. Did hospital staff tell you **who to contact** after you got home if you were worried about your condition or treatment?

100 1 ☐ Yes, they told me to contact **my GP**

100 2 ☐ Yes, they told me to contact the **practice nurse** at my local health centre

100 3 ☐ Yes, they told me to contact **NHS Direct**

100 4 ☐ Yes, I was told to **dial 999**

100 5 ☐ Yes, they told me to return to the **hospital**

100 6 ☐ Yes, I was told to contact **someone else**

0 7 ☐ No, I was not told who to contact

M 8 ☐ I did not need this type of information

M 9 ☐ Don't know/ Can't remember

ALL PATIENTS, please answer the following questions.

K. OVERALL

J1. Overall, did you feel you were treated with respect and dignity while you were in the Emergency Department?

100 1 ☐ Yes, all of the time

50 2 ☐ Yes, some of the time

0 3 ☐ No

J2. Overall, how would you rate the care you received in the Emergency Department?

100 1 ☐ Excellent

80 2 ☐ Very good

60 3 ☐ Good

40 4 ☐ Fair

20 5 ☐ Poor

0 6 ☐ Very poor

L. ABOUT YOU

K1. Are you male or female?

1 ☐ Male

2 ☐ Female

K2. How old are you?

1 ☐ 16 - 35 years

2 ☐ 36 - 50 years

3 ☐ 51 - 65 years

4 ☐ 66 - 80 years

5 ☐ 81 years or older

K3. How old were you when you left full-time education?

1 ☐ 16 years or less

2 ☐ 17 or 18 years

3 ☐ 19 years or over

4 ☐ Still in full-time education

K4. Overall, how would you rate your health during the **past 4 weeks**?

1 ☐ Excellent

2 ☐ Very good

3 ☐ Good

4 ☐ Fair

5 ☐ Poor

6 ☐ Very poor

K5. To which of these ethnic groups would you say you belong? (**tick one only**)

a. WHITE

1 ☐ British

2 ☐ Irish

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

b. MIXED

4 ☐ White and Black Caribbean

5 ☐ White and Black African

6 ☐ White and Asian

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

c. ASIAN OR ASIAN BRITISH

8 ☐ Indian

9 ☐ Pakistani

10 ☐ Bangladeshi

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

d. BLACK OR BLACK BRITISH

12 ☐ Caribbean

13 ☐ African

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

e. CHINESE OR OTHER ETHNIC GROUP

15 ☐ Chinese

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

M. ANY OTHER COMMENTS

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

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

Was there anything that could have been improved?

Any other comments?

THANK YOU VERY MUCH FOR YOUR HELP

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

Please post this questionnaire back in the FREEPOST envelope provided.

No stamp is needed.

Non survey variable definitions: A&E 2003 survey data

1. trustnum: Trust number(please see table 1 for the name and number of trusts)
2. pat_rec: Patient Record Number
3. yob: Year of Birth
4. age: Patient age when the survey was undertaken (2003 – yob), where available it may be preferable to use self reported age instead (question k2)
5. gender: Gender, taken from the trusts' administrative systems, where available it may be preferable to use self reported gender instead (question k1)
    - Not known=0
    - Male=1
    - Female=2
    - Not specified=9
6. eth_f1: Ethnic group from sample file
    - White=1
    - Mixed=2
    - Asian or Asian British=3
    - Black or Black British=4
    - Chinese=5
    - Any other ethnic category=6
7. day_at: Day of attendance at department
8. month_at: Month of attendance at department
9. year_at: Year of attendance at department
10. outcome: Outcome of sending questionnaire
    - Returned useable questionnaire=1
    - Returned undelivered or pt moved house=2
    - Patient reported deceased by tracing service=3
    - Patient reported died by rels or while survey in progress=4
    - Patient reported too ill to complete questionnaire=5
    - Patient opted out or returned blank questionnaire=6
    - Patient was not eligible to fill in questionnaire=7
    - Questionnaire not returned - reason not known=8

11. count: count number of responses- Number of questions answered by the responders (excluding questions on personal attributes such as age, sex and ethnicity).

Table 1. Name and number of trusts

code	2003 Acute Trusts name	TRUST NUM2003
RGT	ADDENBROOKE'S NHS TRUST	273
REM	AINTREE HOSPITALS NHS TRUST	1
RCF	AIREDALE NHS TRUST	2

RTK	ASHFORD AND ST PETER'S HOSPITALS NHS TRUST	222
RF4	BARKING, HAVERING AND REDBRIDGE HOSPITALS NHS TRUST	224
RVL	BARNET AND CHASE FARM HOSPITALS NHS TRUST	228
RFF	BARNSLEY DISTRICT GENERAL HOSPITAL NHS TRUST	207
RNJ	BARTS AND THE LONDON NHS TRUST	256
RDD	BASILDON AND THURROCK UNIVERSITY HOSPITALS NHS TRUST	3
RC1	BEDFORD HOSPITALS NHS TRUST	211
RR1	BIRMINGHAM HEARTLANDS AND SOLIHULL (TEACHING) NHS TRUST	244
RMB	BLACKBURN, HYNDBURN AND RIBBLE VALLEY HEALTH CARE NHS TRUST	5
RXL	BLACKPOOL, FYLDE AND WYRE HOSPITALS NHS TRUST	110
RMC	BOLTON HOSPITALS NHS TRUST	7
RAE	BRADFORD HOSPITALS NHS TRUST	236
RXH	BRIGHTON AND SUSSEX UNIVERSITY HOSPITALS NHS TRUST	111
RG3	BROMLEY HOSPITALS NHS TRUST	239
REU	BURNLEY HEALTH CARE NHS TRUST	245
RJF	BURTON HOSPITALS NHS TRUST	225
RWY	CALDERDALE AND HUDDERSFIELD NHS TRUST	9
RW3	CENTRAL MANCHESTER AND MANCHESTER CHILDREN'S UNIVERSITY HOSPITALS NHS TRUST	11
RQM	CHELSEA AND WESTMINSTER HEALTHCARE NHS TRUST	12
RFS	CHESTERFIELD AND NORTH DERBYSHIRE ROYAL HOSPITAL NHS TRUST	13
RLN	CITY HOSPITALS SUNDERLAND NHS TRUST	15
RJR	COUNTESS OF CHESTER HOSPITAL NHS TRUST	252
???	County Durham & Darlington Acute Hospitals NHS Trust	105
RN7	DARTFORD AND GRAVESHAM NHS TRUST	17
RP5	DONCASTER AND BASSETLAW HOSPITALS NHS TRUST	253
RNA	DUDLEY GROUP OF HOSPITALS NHS TRUST	210
RC3	EALING HOSPITAL NHS TRUST	18
RWH	EAST AND NORTH HERTFORDSHIRE NHS TRUST	19
RJN	EAST CHESHIRE NHS TRUST	20
RVV	EAST KENT HOSPITALS NHS TRUST	22
RA4	EAST SOMERSET NHS TRUST	23
RXC	EAST SUSSEX HOSPITALS NHS TRUST	106
RVR	EPSOM AND ST HELIER NHS TRUST	277
RDE	ESSEX RIVERS HEALTHCARE NHS TRUST	24
RDU	FRIMLEY PARK HOSPITAL NHS TRUST	237
RR7	GATESHEAD HEALTH NHS TRUST	233
RLT	GEORGE ELIOT HOSPITAL NHS TRUST	25
RTE	GLOUCESTERSHIRE HOSPITALS NHS TRUST	112
RJH	GOOD HOPE HOSPITAL NHS TRUST	246
RJ1	GUY'S AND ST THOMAS' NHS TRUST	212
RQN	HAMMERSMITH HOSPITALS NHS TRUST	27
RCD	HARROGATE HEALTH CARE NHS TRUST	28
RD7	HEATHERWOOD AND WEXHAM PARK HOSPITALS NHS TRUST	29
RLQ	HEREFORD HOSPITALS NHS TRUST	30
RQQ	HINCHINGBROOKE HEALTH CARE NHS TRUST	257
RQX	HOMERTON UNIVERSITY HOSPITAL NHS TRUST	234
RWA	HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST	32
RGQ	IPSWICH HOSPITAL NHS TRUST	33
RR2	ISLE OF WIGHT HEALTHCARE NHS TRUST	34
RGP	JAMES PAGET HEALTHCARE NHS TRUST	206

RNQ	KETTERING GENERAL HOSPITAL NHS TRUST	35
RJZ	KING'S COLLEGE HOSPITAL NHS TRUST	36
RCX	KINGS LYNN AND WISBECH HOSPITALS NHS TRUST	37
RAX	KINGSTON HOSPITAL NHS TRUST	400
RXN	LANCASHIRE TEACHING HOSPITALS NHS TRUST	107
RR8	LEEDS TEACHING HOSPITALS NHS TRUST	38
REP	LIVERPOOL WOMENS HOSPITAL NHS TRUST	40
RC9	LUTON AND DUNSTABLE HOSPITAL NHS TRUST	251
RWF	MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST	248
RJ6	MAYDAY HEALTHCARE NHS TRUST	220
RPA	MEDWAY NHS TRUST	254
RQ8	MID ESSEX HOSPITAL SERVICES NHS TRUST	41
RJD	MID STAFFORDSHIRE GENERAL HOSPITALS NHS TRUST	231
RXF	MID YORKSHIRE HOSPITALS NHS TRUST	108
RD8	MILTON KEYNES GENERAL HOSPITAL NHS TRUST	43
RP6	MOORFIELDS EYE HOSPITAL NHS TRUST	44
RTX	MORECAMBE BAY HOSPITALS NHS TRUST	45
RNH	NEWHAM HEALTHCARE NHS TRUST	47
RM1	NORFOLK AND NORWICH UNIVERSITY HOSPITAL NHS TRUST	260
RVJ	NORTH BRISTOL NHS TRUST	274
RWW	NORTH CHESHIRE HOSPITALS NHS TRUST	238
RNL	NORTH CUMBRIA ACUTE HOSPITALS NHS TRUST	48
RR9	North Durham Health Care NHS Trust	49
RN5	NORTH HAMPSHIRE HOSPITALS NHS TRUST	261
RAP	NORTH MIDDLESEX UNIVERSITY HOSPITAL NHS TRUST	50
RJE	NORTH STAFFORDSHIRE HOSPITAL NHS TRUST	51
RVW	NORTH TEES AND HARTLEPOOL NHS TRUST	52
RV8	NORTH WEST LONDON HOSPITALS NHS TRUST	53
RNS	NORTHAMPTON GENERAL HOSPITAL NHS TRUST	208
RBZ	NORTHERN DEVON HEALTHCARE NHS TRUST	55
RJL	NORTHERN LINCOLNSHIRE AND GOOLE HOSPITALS NHS TRUST	56
RTF	NORTHUMBRIA HEALTH CARE NHS TRUST	201
RTH	OXFORD RADCLIFFE HOSPITAL NHS TRUST	259
RW6	PENNINE ACUTE HOSPITALS NHS TRUST	109
RGN	PETERBOROUGH HOSPITALS NHS TRUST	272
RK9	PLYMOUTH HOSPITALS NHS TRUST	270
RD3	POOLE HOSPITALS NHS TRUST	59
RHU	PORTSMOUTH HOSPITALS NHS TRUST	60
RG2	QUEEN ELIZABETH HOSPITAL NHS TRUST	223
RGZ	QUEEN MARY'S SIDCUP NHS TRUST	271
RFK	QUEEN'S MEDICAL CENTRE, NOTTINGHAM UNIVERSITY HOSPITAL NHS TRUST	258
RL1	ROBERT JONES AND AGNES HUNT ORTHOPAEDIC AND DISTRICT HOSPITAL NHS TRUST	63
RFR	ROTHERHAM GENERAL HOSPITALS NHS TRUST	65
RHW	ROYAL BERKSHIRE AND BATTLE HOSPITALS NHS TRUST	209
RDZ	ROYAL BOURNEMOUTH AND CHRISTCHURCH HOSPITALS NHS TRUST	216
REF	ROYAL CORNWALL HOSPITALS NHS TRUST	67
RH8	ROYAL DEVON AND EXETER HEALTHCARE NHS TRUST	202
RAL	ROYAL FREE HAMPSTEAD NHS TRUST	235
RQ6	ROYAL LIVERPOOL AND BROADGREEN UNIVERSITY HOSPITALS NHS TRUST	68

RLZ	ROYAL SHREWSBURY HOSPITALS NHS TRUST	71
RA2	ROYAL SURREY COUNTY HOSPITAL NHS TRUST	72
RD1	ROYAL UNITED HOSPITAL BATH NHS TRUST	73
RPR	ROYAL WEST SUSSEX NHS TRUST	74
RM3	SALFORD ROYAL HOSPITALS NHS TRUST	267
RNZ	SALISBURY HEALTH CARE NHS TRUST	75
RXK	SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST	113
RCC	SCARBOROUGH AND NORTH EAST YORKSHIRE HEALTH CARE NHS TRUST	77
RHQ	SHEFFIELD TEACHING HOSPITALS NHS TRUST	78
RK5	SHERWOOD FOREST HOSPITALS NHS TRUST	79
RH2	SOUTH BUCKINGHAMSHIRE NHS TRUST	80
RA9	SOUTH DEVON HEALTH CARE NHS TRUST	229
RTA	South Durham Health Care NHS Trust	81
RM2	SOUTH MANCHESTER UNIVERSITY HOSPITALS NHS TRUST	82
RTR	SOUTH TEES HOSPITALS NHS TRUST	83
RE9	SOUTH TYNESIDE HEALTH CARE NHS TRUST	84
RJC	SOUTH WARWICKSHIRE GENERAL HOSPITALS NHS TRUST	85
RHM	SOUTHAMPTON UNIVERSITY HOSPITALS NHS TRUST	232
RAJ	SOUTHEND HOSPITAL NHS TRUST	86
RTG	SOUTHERN DERBYSHIRE ACUTE HOSPITALS NHS TRUST	230
RVY	SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	87
RJ7	ST GEORGE'S HEALTHCARE NHS TRUST	264
RBN	ST HELENS AND KNOWSLEY HOSPITALS NHS TRUST	88
RJ5	ST MARY'S NHS TRUST	226
RWJ	STOCKPORT NHS TRUST	203
RNT	STOKE MANDEVILLE HOSPITAL NHS TRUST	218
RTP	SURREY AND SUSSEX HEALTHCARE NHS TRUST	278
RN3	SWINDON AND MARLBOROUGH NHS TRUST	200
RMP	TAMESIDE AND GLOSSOP ACUTE SERVICES NHS TRUST	89
RBA	TAUNTON AND SOMERSET NHS TRUST	90
RAS	THE HILLINGDON HOSPITAL NHS TRUST	31
RJ2	THE LEWISHAM HOSPITAL NHS TRUST	39
RBT	THE MID CHESHIRE HOSPITALS NHS TRUST	227
RTD	THE NEWCASTLE UPON TYNE HOSPITALS NHS TRUST	46
RQW	THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST	61
RKF	THE PRINCESS ROYAL HOSPITAL NHS TRUST	62
RL4	THE ROYAL WOLVERHAMPTON HOSPITALS NHS TRUST	217
RM4	TRAFFORD HEALTHCARE NHS TRUST	266
RA7	UNITED BRISTOL HEALTHCARE NHS TRUST	91
RWD	UNITED LINCOLNSHIRE HOSPITALS NHS TRUST	92
RRV	UNIVERSITY COLLEGE LONDON HOSPITALS NHS TRUST	93
RRK	UNIVERSITY HOSPITAL BIRMINGHAM NHS TRUST	240
RKB	UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST	94
RWE	UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST	95
RBK	WALSALL HOSPITALS NHS TRUST	96
RBD	WEST DORSET GENERAL HOSPITALS NHS TRUST	98
RWG	WEST HERTFORDSHIRE HOSPITALS NHS TRUST	265
RFW	WEST MIDDLESEX UNIVERSITY NHS TRUST	100
RGR	WEST SUFFOLK HOSPITALS NHS TRUST	102
RA3	WESTON AREA HEALTH NHS TRUST	103

RGC	WHIPPS CROSS UNIVERSITY HOSPITAL NHS TRUST	219
RKE	WHITTINGTON HOSPITAL NHS TRUST	104
RN1	WINCHESTER AND EASTLEIGH HEALTHCARE NHS TRUST	242
RBL	WIRRAL HOSPITAL NHS TRUST	205
RWP	WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST	204
RPL	WORTHING AND SOUTHLANDS HOSPITALS NHS TRUST	247
RRF	WRIGHTINGTON, WIGAN AND LEIGH NHS TRUST	221
RCB	YORK HEALTH SERVICES NHS TRUST	241
RPC	THE QUEEN VICTORIA HOSPITAL NHS TRUST	243
RLU	BIRMINGHAM WOMEN'S HEALTH CARE NHS TRUST	4
RBV	CHRISTIE HOSPITAL NHS TRUST	14
REN	CLATTERBRIDGE CENTRE FOR ONCOLOGY NHS TRUST	16
RCS	NOTTINGHAM CITY HOSPITAL NHS TRUST	57
RBF	NUFFIELD ORTHOPAEDIC NHS TRUST	58
RGM	PAPWORTH HOSPITAL NHS TRUST	215
RT3	ROYAL BROMPTON AND HAREFIELD NHS TRUST	66
RBB	ROYAL NATIONAL HOSPITAL FOR RHEUMATIC DISEASES NHS TRUST	69
RRJ	ROYAL ORTHOPAEDIC HOSPITAL NHS TRUST	262
RBQ	THE CARDIOTHORACIC CENTRE - LIVERPOOL NHS TRUST	10
RPY	THE ROYAL MARSDEN NHS TRUST	263
RAN	THE ROYAL NATIONAL ORTHOPAEDIC HOSPITAL NHS TRUST	70
RET	WALTON CENTRE FOR NEUROLOGY AND NEUROSURGERY NHS TRUST	97

trustnum	2003 Acute Trusts name	NHS organisation code
1	AINTREE HOSPITALS NHS TRUST	REM
2	AIREDALE NHS TRUST	RCF
3	BASILDON AND THURROCK UNIVERSITY HOSPITALS NHS TRUST	RDD
4	BIRMINGHAM WOMEN'S HEALTH CARE NHS TRUST	RLU
5	BLACKBURN, HYNDBURN AND RIBBLE VALLEY HEALTH CARE NHS TRUST	RMB
7	BOLTON HOSPITALS NHS TRUST	RMC
9	CALDERDALE AND HUDDERSFIELD NHS TRUST	RWY
10	THE CARDIOTHORACIC CENTRE - LIVERPOOL NHS TRUST	RBQ
11	CENTRAL MANCHESTER AND MANCHESTER CHILDREN'S UNIVERSITY HOSPITALS NHS TRUST	RW3
12	CHELSEA AND WESTMINSTER HEALTHCARE NHS TRUST	RQM
13	CHESTERFIELD AND NORTH DERBYSHIRE ROYAL HOSPITAL NHS TRUST	RFS
14	CHRISTIE HOSPITAL NHS TRUST	RBV
15	CITY HOSPITALS SUNDERLAND NHS TRUST	RLN
16	CLATTERBRIDGE CENTRE FOR ONCOLOGY NHS TRUST	REN
17	DARTFORD AND GRAVESHAM NHS TRUST	RN7
18	EALING HOSPITAL NHS TRUST	RC3
19	EAST AND NORTH HERTFORDSHIRE NHS TRUST	RWH
20	EAST CHESHIRE NHS TRUST	RJN
22	EAST KENT HOSPITALS NHS TRUST	RVV
23	EAST SOMERSET NHS TRUST	RA4
24	ESSEX RIVERS HEALTHCARE NHS TRUST	RDE
25	GEORGE ELIOT HOSPITAL NHS TRUST	RLT
27	HAMMERSMITH HOSPITALS NHS TRUST	RQN
28	HARROGATE HEALTH CARE NHS TRUST	RCD
29	HEATHERWOOD AND WEXHAM PARK HOSPITALS NHS TRUST	RD7
30	HEREFORD HOSPITALS NHS TRUST	RLQ
31	THE HILLINGDON HOSPITAL NHS TRUST	RAS
32	HULL AND EAST YORKSHIRE HOSPITALS NHS TRUST	RWA
33	IPSWICH HOSPITAL NHS TRUST	RGQ
34	ISLE OF WIGHT HEALTHCARE NHS TRUST	RR2
35	KETTERING GENERAL HOSPITAL NHS TRUST	RNQ
36	KING'S COLLEGE HOSPITAL NHS TRUST	RJZ
37	KINGS LYNN AND WISBECH HOSPITALS NHS TRUST	RCX

38	LEEDS TEACHING HOSPITALS NHS TRUST	RR8
39	THE LEWISHAM HOSPITAL NHS TRUST	RJ2
40	LIVERPOOL WOMENS HOSPITAL NHS TRUST	REP
41	MID ESSEX HOSPITAL SERVICES NHS TRUST	RQ8
43	MILTON KEYNES GENERAL HOSPITAL NHS TRUST	RD8
44	MOORFIELDS EYE HOSPITAL NHS TRUST	RP6
45	MORECAMBE BAY HOSPITALS NHS TRUST	RTX
46	THE NEWCASTLE UPON TYNE HOSPITALS NHS TRUST	RTD
47	NEWHAM HEALTHCARE NHS TRUST	RNH
48	NORTH CUMBRIA ACUTE HOSPITALS NHS TRUST	RNL
49	North Durham Health Care NHS Trust	RR9
50	NORTH MIDDLESEX UNIVERSITY HOSPITAL NHS TRUST	RAP
51	NORTH STAFFORDSHIRE HOSPITAL NHS TRUST	RJE
52	NORTH TEES AND HARTLEPOOL NHS TRUST	RVW
53	NORTH WEST LONDON HOSPITALS NHS TRUST	RV8
55	NORTHERN DEVON HEALTHCARE NHS TRUST	RBZ
56	NORTHERN LINCOLNSHIRE AND GOOLE HOSPITALS NHS TRUST	RJL
57	NOTTINGHAM CITY HOSPITAL NHS TRUST	RCS
58	NUFFIELD ORTHOPAEDIC NHS TRUST	RBF
59	POOLE HOSPITALS NHS TRUST	RD3
60	PORTSMOUTH HOSPITALS NHS TRUST	RHU
61	THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST	RQW
62	THE PRINCESS ROYAL HOSPITAL NHS TRUST	RKF
63	ROBERT JONES AND AGNES HUNT ORTHOPAEDIC AND DISTRICT HOSPITAL NHS TRUST	RL1
65	ROTHERHAM GENERAL HOSPITALS NHS TRUST	RFR
66	ROYAL BROMPTON AND HAREFIELD NHS TRUST	RT3
67	ROYAL CORNWALL HOSPITALS NHS TRUST	REF
68	ROYAL LIVERPOOL AND BROADGREEN UNIVERSITY HOSPITALS NHS TRUST	RQ6
69	ROYAL NATIONAL HOSPITAL FOR RHEUMATIC DISEASES NHS TRUST	RBB
70	THE ROYAL NATIONAL ORTHOPAEDIC HOSPITAL NHS TRUST	RAN
71	ROYAL SHREWSBURY HOSPITALS NHS TRUST	RLZ
72	ROYAL SURREY COUNTY HOSPITAL NHS TRUST	RA2
73	ROYAL UNITED HOSPITAL BATH NHS TRUST	RD1
74	ROYAL WEST SUSSEX NHS TRUST	RPR
75	SALISBURY HEALTH CARE NHS TRUST	RNZ
77	SCARBOROUGH AND NORTH EAST YORKSHIRE HEALTH CARE NHS TRUST	RCC

78	SHEFFIELD TEACHING HOSPITALS NHS TRUST	RHQ
79	SHERWOOD FOREST HOSPITALS NHS TRUST	RK5
80	SOUTH BUCKINGHAMSHIRE NHS TRUST	RH2
81	South Durham Health Care NHS Trust	RTA
82	SOUTH MANCHESTER UNIVERSITY HOSPITALS NHS TRUST	RM2
83	SOUTH TEES HOSPITALS NHS TRUST	RTR
84	SOUTH TYNESIDE HEALTH CARE NHS TRUST	RE9
85	SOUTH WARWICKSHIRE GENERAL HOSPITALS NHS TRUST	RJC
86	SOUTHEND HOSPITAL NHS TRUST	RAJ
87	SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	RVY
88	ST HELENS AND KNOWSLEY HOSPITALS NHS TRUST	RBN
89	TAMESIDE AND GLOSSOP ACUTE SERVICES NHS TRUST	RMP
90	TAUNTON AND SOMERSET NHS TRUST	RBA
91	UNITED BRISTOL HEALTHCARE NHS TRUST	RA7
92	UNITED LINCOLNSHIRE HOSPITALS NHS TRUST	RWD
93	UNIVERSITY COLLEGE LONDON HOSPITALS NHS TRUST	RRV
94	UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST	RKB
95	UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST	RWE
96	WALSALL HOSPITALS NHS TRUST	RBK
97	WALTON CENTRE FOR NEUROLOGY AND NEUROSURGERY NHS TRUST	RET
98	WEST DORSET GENERAL HOSPITALS NHS TRUST	RBD
100	WEST MIDDLESEX UNIVERSITY NHS TRUST	RFW
102	WEST SUFFOLK HOSPITALS NHS TRUST	RGR
103	WESTON AREA HEALTH NHS TRUST	RA3
104	WHITTINGTON HOSPITAL NHS TRUST	RKE
105	County Durham & Darlington Acute Hospitals NHS Trust	RXP
106	EAST SUSSEX HOSPITALS NHS TRUST	RXC
107	LANCASHIRE TEACHING HOSPITALS NHS TRUST	RXN
108	MID YORKSHIRE HOSPITALS NHS TRUST	RXF
109	PENNINE ACUTE HOSPITALS NHS TRUST	RW6
110	BLACKPOOL, FYLDE AND WYRE HOSPITALS NHS TRUST	RXL
111	BRIGHTON AND SUSSEX UNIVERSITY HOSPITALS NHS TRUST	RXH
112	GLOUCESTERSHIRE HOSPITALS NHS TRUST	RTE
113	SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST	RXK
200	SWINDON AND MARLBOROUGH NHS TRUST	RN3
201	NORTHUMBRIA HEALTH CARE NHS TRUST	RTF

202	ROYAL DEVON AND EXETER HEALTHCARE NHS TRUST	RH8
203	STOCKPORT NHS TRUST	RWJ
204	WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST	RWP
205	WIRRAL HOSPITAL NHS TRUST	RBL
206	JAMES PAGET HEALTHCARE NHS TRUST	RGP
207	BARNSLEY DISTRICT GENERAL HOSPITAL NHS TRUST	RFF
208	NORTHAMPTON GENERAL HOSPITAL NHS TRUST	RNS
209	ROYAL BERKSHIRE AND BATTLE HOSPITALS NHS TRUST	RHW
210	DUDLEY GROUP OF HOSPITALS NHS TRUST	RNA
211	BEDFORD HOSPITALS NHS TRUST	RC1
212	GUY'S AND ST THOMAS' NHS TRUST	RJ1
215	PAPWORTH HOSPITAL NHS TRUST	RGM
216	ROYAL BOURNEMOUTH AND CHRISTCHURCH HOSPITALS NHS TRUST	RDZ
217	THE ROYAL WOLVERHAMPTON HOSPITALS NHS TRUST	RL4
218	STOKE MANDEVILLE HOSPITAL NHS TRUST	RNT
219	WHIPPS CROSS UNIVERSITY HOSPITAL NHS TRUST	RGC
220	MAYDAY HEALTHCARE NHS TRUST	RJ6
221	WRIGHTINGTON, WIGAN AND LEIGH NHS TRUST	RRF
222	ASHFORD AND ST PETER'S HOSPITALS NHS TRUST	RTK
223	QUEEN ELIZABETH HOSPITAL NHS TRUST	RG2
224	BARKING, HAVERING AND REDBRIDGE HOSPITALS NHS TRUST	RF4
225	BURTON HOSPITALS NHS TRUST	RJF
226	ST MARY'S NHS TRUST	RJ5
227	THE MID CHESHIRE HOSPITALS NHS TRUST	RBT
228	BARNET AND CHASE FARM HOSPITALS NHS TRUST	RVL
229	SOUTH DEVON HEALTH CARE NHS TRUST	RA9
230	SOUTHERN DERBYSHIRE ACUTE HOSPITALS NHS TRUST	RTG
231	MID STAFFORDSHIRE GENERAL HOSPITALS NHS TRUST	RJD
232	SOUTHAMPTON UNIVERSITY HOSPITALS NHS TRUST	RHM
233	GATESHEAD HEALTH NHS TRUST	RR7
234	HOMERTON UNIVERSITY HOSPITAL NHS TRUST	RQX
235	ROYAL FREE HAMPSTEAD NHS TRUST	RAL
236	BRADFORD HOSPITALS NHS TRUST	RAE
237	FRIMLEY PARK HOSPITAL NHS TRUST	RDU
238	NORTH CHESHIRE HOSPITALS NHS TRUST	RWW
239	BROMLEY HOSPITALS NHS TRUST	RG3

240	UNIVERSITY HOSPITAL BIRMINGHAM NHS TRUST	RRK
241	YORK HEALTH SERVICES NHS TRUST	RCB
242	WINCHESTER AND EASTLEIGH HEALTHCARE NHS TRUST	RN1
243	THE QUEEN VICTORIA HOSPITAL NHS TRUST	RPC
244	BIRMINGHAM HEARTLANDS AND SOLIHULL (TEACHING) NHS TRUST	RR1
245	BURNLEY HEALTH CARE NHS TRUST	REU
246	GOOD HOPE HOSPITAL NHS TRUST	RJH
247	WORTHING AND SOUTHLANDS HOSPITALS NHS TRUST	RPL
248	MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST	RWF
251	LUTON AND DUNSTABLE HOSPITAL NHS TRUST	RC9
252	COUNTESS OF CHESTER HOSPITAL NHS TRUST	RJR
253	DONCASTER AND BASSETLAW HOSPITALS NHS TRUST	RP5
254	MEDWAY NHS TRUST	RPA
256	BARTS AND THE LONDON NHS TRUST	RNJ
257	HINCHINGBROOKE HEALTH CARE NHS TRUST	RQQ
258	QUEEN'S MEDICAL CENTRE, NOTTINGHAM UNIVERSITY HOSPITAL NHS TRUST	RFK
259	OXFORD RADCLIFFE HOSPITAL NHS TRUST	RTH
260	NORFOLK AND NORWICH UNIVERSITY HOSPITAL NHS TRUST	RM1
261	NORTH HAMPSHIRE HOSPITALS NHS TRUST	RN5
262	ROYAL ORTHOPAEDIC HOSPITAL NHS TRUST	RRJ
263	THE ROYAL MARSDEN NHS TRUST	RPY
264	ST GEORGE'S HEALTHCARE NHS TRUST	RJ7
265	WEST HERTFORDSHIRE HOSPITALS NHS TRUST	RWG
266	TRAFFORD HEALTHCARE NHS TRUST	RM4
267	SALFORD ROYAL HOSPITALS NHS TRUST	RM3
270	PLYMOUTH HOSPITALS NHS TRUST	RK9
271	QUEEN MARY'S SIDCUP NHS TRUST	RGZ
272	PETERBOROUGH HOSPITALS NHS TRUST	RGN
273	ADDENBROOKE'S NHS TRUST	RGT
274	NORTH BRISTOL NHS TRUST	RVJ
277	EPSOM AND ST HELIER NHS TRUST	RVR
278	SURREY AND SUSSEX HEALTHCARE NHS TRUST	RTP
400	KINGSTON HOSPITAL NHS TRUST	RAX

NHS PATIENT SURVEY PROGRAMME
EMERGENCY DEPARTMENT PATIENT SURVEY 2003

About the survey

The Emergency Department Survey 2003 is part of the NHS Patient Survey Programme, initiated by the Department of Health and now the responsibility of the Commission for Health Improvement (CHI). Over 59,000 patients from 155 English NHS trusts participated in this survey. The survey was designed to provide actionable feedback to each participating trust on patients' views of the care they had received in emergency departments, as well as providing CHI with patient focused indicators to feed into the 2003 performance ratings for acute and specialist NHS trusts.

The survey methodology

The sample included adult patients who had attended a main emergency department (excluding minor injuries units and medical or surgical admissions units) during either November 2002 or January 2003.

Staff at each NHS trust identified patients who were eligible for inclusion and drew a random sample of 850 patients, following a standard procedure set out in the survey guidance. The sampled patients were sent a questionnaire with a covering letter. Patients who did not respond were sent up to two reminders.

In total, over 131,000 patients were sampled. Completed questionnaires were received back from 59,155 – a response rate of 46%, after adjusting for some patients who proved to be ineligible. Response rates varied between trusts, from 26% to 61%.

Nationally, of all those patients who returned completed questionnaires:

48% were men and 52% were women
28% of respondents were aged 16-35
23% were aged 36-50
22% were aged 51-65
19% were aged 66-80
7% were aged 81 or over

The sex and age profile of respondents varied between trusts.

FURTHER INFORMATION

Full details of the survey methodology can be found at:
http://www.nhssurveys.org/docs/Emergency_Guidance_V12b.pdf

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

More information on the 2002 / 2003 NHS performance ratings is available on the CHI website (www.chi.nhs.uk/ratings).

Survey Indicator Methodology
Commission for Health Improvement (CHI)

Outpatients Survey 2003
&
Emergency Survey 2003

1. Introduction

This document outlines the method used by the Commission for Health Improvement (CHI) to score the performance indicator questions included within the Outpatients Survey, carried out by specialist and acute NHS trusts in Spring 2003, and the Emergency Survey conducted in the same period by acute trusts. It also details the methodology used to calculate the overall scores for each individual trust, in terms the five domains of patient experience used by the Department of Health (see Figure 1.1).

Figure 1.1: Domains of patient experience

Domains:

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

2. Domains: Selected indicator questions

The Outpatient core survey consists of 50 pre-coded questions, and one open ended question regarding any further comments. Of these, 37 questions were classified as being potential evaluative questions, and were allocated to one of the five Department of Health patient experience domains. The Emergency core survey consists of 47 pre-coded questions, and one open ended question. Of these, 35 questions were classed as potential evaluative questions, and were allocated to one of the five domains.

The criteria listed in Figure 2.1 were used to assess the suitability of each individual question, in terms of its viability as an indicator of performance. Using these criteria, a number of questions were then selected from each domain to be used as performance indicators, for each survey. See Appendix 1 and 2 for the questions included within each domain.

Figure 2.1 Criteria for selecting performance indicator questions:

- Patient priorities:

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

- Wide range of issues within domains:

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

- Overlap:

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

- Numbers of questions in each domain:

  There should be between 3 and 8 questions in each domain for each survey.

- Ease of evaluating responses:

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

- Non-response:

  Questions should have low numbers of missing responses

3. Scoring: Individual indicator questions

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

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

For example, question J2 (see Figure 3.1) in the Outpatients survey asks whether the respondent felt they were treated with respect and dignity. The option of "No" has been allocated a score of 0, as this suggests that improvements to the patient experience are required. A score of 100 has been assigned to the option "Yes, all of the time" as it reflects a positive patient experience. The remaining option, "Yes, some of the time", has been assigned a score of 50 as the patient felt that some degree of respect and dignity was received, although not consistently. Hence it has been placed on the midpoint of the scale.

Figure 3.1 Scoring example: Question J2 (Outpatients)

J2. Overall, did you feel you were treated with respect and dignity while you were at the Outpatient Department?	
Yes, all of the time	100
Yes, some of the time	50
No	0

Where a number of options lie between the negative and positive responses, they are placed in appropriate positions along the scale. For example, question A1 in the Outpatients survey asks how long the patient waited for an appointment (see Figure 3.2). The options include:

- Up to 1 month
- More than 1 month but no more than 3 months
- More than 3 months but no more than 5 months
- More than 5 months but no more than 12 months
- More than 12 months but no more than 18 months, or
- More than 18 months
- Went to Outpatients without an appointment
- Don't know/Can't remember

A score of 100 will be assigned to a response that it took "up to one month", as this is best practice in terms of patient experience. A response that it took "more than 18 months" would be given a score of 0, and so the remaining four answers would be assigned a score that reflects their position in terms of best practice, spread evenly across the scale. Hence the option "More than 1 month…" has been assigned a score of 80, "More than 3 months" will achieve a score of 60, "More than 5 months" would be 40, and the response that it took "More than 12 months…" would score 20 for the trust.

If the patient had gone to Outpatients without an appointment, or did not know/could not remember how long it had taken, this would be classified as a "missing" response, as these options are not a direct measure of how long a person had to wait to get an appointment.

Figure 3.2 Scoring example: Question A1 (Outpatients)

A1. Overall, from the time you were first told you needed an appointment to the time you went to the Outpatients Department, how long did you wait for an appointment?	
Up to 1 month	100
More than 1 month but no more than 3 months	80
More than 3 months but no more than 5 months	60
More than 5 months but no more than 12 months	40
More than 12 months but no more than 18 months	20
More than 18 months	0
I went to Outpatients without an appointment	Missing
Don't know/ Can't remember	Missing

4. Methodology: Overall domain scores

The scores for each domain per trust are calculated using the following method, described according to each stage. This was done separately for each survey, then the results were combined for the relevant trusts.

To summarise, age-by-sex weightings are calculated to adjust for any variation between trusts that results from differences in the age and sex of patients. A weight is calculated for each respondent by dividing the national proportion of respondents in their age-by-sex group by the corresponding trust proportion. As shown in section 4.4, the final domain score is calculated by dividing the sum of weighted scores for all eligible responses by the weighted number of eligible respondents.

The reason for weighting is that younger people and women tend to be more critical in their responses than older people and men. If a trust has a large population of young people or women, their performance might be judged more harshly than if there was a more consistent age/sex distribution.

The exact stages are described as follows:

4.1 Weighted analysis

The first stage of the analysis involves calculating national age-by-sex proportions. It must be noted that the term "national proportion" is used loosely here as it is obtained from pooling the survey data from all trusts, and is therefore based on the respondent population rather than the entire UK population.

The questionnaire asked respondents to state which age category they belong to. These age groups were used to calculate the number of people within each age group (see Figure 4.1.1 for the categories). The two oldest age groups (66-80 years and 81+ years) were combined in the analysis, as a considerably small number of respondents were within the oldest category of 81+ years. This would have led to a very high weighting for respondents of this age, and so merging the categories allowed for the weightings to be levelled out.

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

The national age-by-sex proportions relate to the proportion of males and females within each age group. With the Outpatients survey, as shown in Figure 4.1.1, the proportion of males aged 51-65 years is 0.125385474, the proportion of females aged 51-65 years is 0.166458501, etc. See Appendix 5 for Emergency Department national proportions.

Figure 4.1.1 National Proportions (Outpatients)

Sex	Age Group	National Proportion
Male	16-35	0.035214926
	36-50	0.062095873
	51-65	0.125385474
	66+	0.194267903
Female	16-35	0.077713793
	36-50	0.115592497
	51-65	0.166458501
	66+	0.223271031

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

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

If, for example, a low proportion of males aged between 51 and 65 years within Trust A responded to the survey, in comparison to the national proportion, then this group would be under-represented in terms of the final scores. Dividing the national proportion by the trust's proportion would result in a greater weighting for members of this group (see Figure 4.1.2). This would increase the influence of responses made by patients within that group over the final score, thus counteracting the low representation.

Figure 4.1.2 Proportion and Weighting for Trust A

Sex	Age Group	National Proportion	Trust A Proportion	Trust A Weight (National/Trust A)
Male	16-35	0.035	0.036	0.974
	36-50	0.062	0.070	0.892
	51-65	**0.125**	**0.094**	**1.334**
	66+	0.194	0.190	1.023
Female	16-35	0.078	0.090	0.868
	36-50	0.116	0.115	1.006
	51-65	0.166	0.171	0.974
	66+	0.223	0.235	0.950

Note: All proportions are given to three decimals places for this example. The analysis included these figures to nine decimal places (see Appendix 5)

Likewise, if a considerably higher proportion of females aged between 36 and 50 from Trust B responded to the survey (see Figure 4.1.3), then this group would be over-represented within the sample, compared to national representation of this group. Subsequently this age group would have a greater influence over the final score. To counteract this, dividing the national proportion by the proportion for Trust B would

result in a lower weighting for members of this group, and would in effect reduce the disproportionate influence held by this group.

Figure 4.1.3 Proportion and Weighting for Trust B

Sex	Age Group	National Proportion	Trust B Proportion	Trust B Weight (National/Trust B)
Male	16-35	0.035	0.033	1.072
	36-50	0.062	0.059	1.044
	51-65	0.125	0.125	1.007
	66+	0.194	0.183	1.059
Female	16-35	0.078	0.068	1.140
	36-50	**0.116**	**0.151**	**0.763**
	51-65	0.166	0.160	1.042
	66+	0.223	0.220	1.013

Note: All proportions are given to three decimals places for this example. The analysis included these figures to nine decimal places (see Appendix 5)

4.2 Obtaining the numerators for each domain score

The responses given by each respondent were entered into a dataset in terms of the 0-100 scale described in section 3. Each row corresponds to an individual patient, and each column relates to a performance indicator question. For those questions that the patient did not answer (or received a missing score for), the relevant cell remains empty. Alongside these are the weightings allocated to each patient (see Figure 4.2.1).

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

Respondent	Question:					Weight
	B2	B3	C1	C2	J2	
1	100	50	67	100	100	0.974
2	50	100	100	.	100	0.868
3	.	.	67	100	100	1.006

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

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

Patient	Numerators:					Weight
	B2	B3	C1	C2	J2	
1	97.4	48.7	65.258	97.4	97.4	0.974
2	43.4	86.8	86.8	.	86.8	0.868
3	.	.	67.402	100.6	100.6	1.006

4.3 Obtaining the denominators for each domain score

A second dataset was then created. This contained a column for each question, grouped into domains, and again with each row corresponding to an individual respondent. A value of one was entered for the questions whereby a response had

been given by the patient, and all questions that had been left unanswered or allocated a scoring of "missing" (see section 3) were set to missing (see Figure 4.3.1).

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

Respondent	Question:					Weight
	B2	B3	C1	C2	J2	
1	1	1	1	1	1	0.974
2	1	1	1	.	1	0.868
3	.	.	1	1	1	1.006

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

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

Patient	Denominators:				
	B2	B3	C1	C2	J2
1	0.974	0.974	0.974	0.974	0.974
2	0.868	0.868	0.868	.	0.868
3	.	.	1.006	1.006	1.006

4.4 Final calculation

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

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

$$\frac{97.4+48.7+65.258+97.4+97.4+43.4+86.8+86.8+86.8+67.402+100.6+100.6}{0.974+0.974+0.974+0.974+0.974+0.868+0.868+0.868+0.868+1.006+1.006+1.006}$$

$$=86.141$$

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

4.5 Combining Outpatients and Emergency scores

The Outpatients survey was carried out by 171 trusts, including 16 specialist trusts. Of these, 155 acute trusts also carried out the Emergency survey. However, one trust was excluded from the analysis due to data quality issues.

Those that only submitted data from the Outpatients survey will be assigned a final score based on that result. However, those trusts that completed both surveys will be given an aggregate score combining the two survey results.

Analysis of the survey data showed that trusts tended to score lower for Emergency Department surveys than for Outpatients. Therefore, the implication of taking the mean for both surveys is that the Emergency Department scores usually pull the overall score down. This would put the trusts that only carried the Outpatients survey at an unfair advantage, as their scores would not be "dragged down" in the same way as for trusts that carried out both surveys.

This was resolved by using Z scores to calculate the mean score for both surveys. This is unique to the Outpatients and Emergency surveys, due to the need to combine scores. The scores for the PCT survey do not need to be transformed into Z scores.

4.5.1 Using Z scores to arrive at the mean score

The scores for each trust were transformed into z-scores. This transforms a trusts score for one domain to a value on a scale with a mean of 0. This enables the scores within each survey to be combined.

The z-score is calculated by subtracting the mean score of all trusts from the trust's individual score. This figure is then divided by the standard deviation of the scores. This results in a set of values for each survey in which the mean value is always zero and the standard deviation is 1.

For example, in the Outpatient survey the trusts' average scores for access had a mean of 77 and standard deviation of 2.6, while in the A&E survey the mean score was 68 with a standard deviation of 6. An Outpatient score of 82 would then become (82-77)/2.6 = 1.92, and an A&E score of 66 would become (66-68)/6 = -0.33. These scores are then averaged to produce a final domain score of 0.79. A score above 0 is better than average. See Appendix 5 for details on the means and standard deviations used to calculate the z-scores.

Appendix 1: Performance indicator questions, grouped within each domain
Outpatients

Access and Waiting
A1. Overall, from the time you were first told you needed an appointment to the time you went to the Outpatients Department, how long did you wait for an appointment?
A4. Was your appointment changed by the hospital?
B1. How long after the stated appointment time did the appointment start?

Safe, high quality, coordinated care
A3. Before your appointment, did you know who to contact if your symptoms or condition got worse?
D8. Did you have confidence and trust in the doctor examining and treating you?
D9. Did the doctor seem aware of your medical history?
E4. Did you have confidence and trust in (the other person you saw)?
J1. How well organised was the Outpatients Department you visited?

Better information, more choice
A2. Before your appointment, did you know the reason for the appointment?
D4. Did the doctor explain the reasons for any treatment or action in a way that you could understand?
F4. While you were in the Outpatients Department, how much information about your condition or treatment was given to you?
F6. Were you involved as much as you wanted to be in decisions about your care and treatment?
G4. Did a member of staff explain the results of the tests in a way you could understand?

Building relationships

D2. Did you have enough time to discuss your health or medical problem with the doctor?

D5. Did the doctor listen to what you had to say?

D7. If you had important questions to ask the doctor, did you get answers that you could understand?

E3. If you had important questions to ask the [other person you saw], did you get answers that you could understand?

F3. Did doctors and/or other staff talk in front of you as if you weren't there?

Clean, comfortable, friendly place to be

B2. Were you told how long you would have to wait? [and was that information accurate?]

B3. Were you told why you had to wait? [in OP waiting area]

C1. In your opinion, how clean was the Outpatients Department?

C2. How clean were the toilets at the Outpatients Department?

J2. Overall, did you feel you were treated with respect and dignity while you were at the Outpatient Department?

Appendix 2: Performance indicator questions, grouped within each domain
Emergency

Access and Waiting	
B1.	Following your arrival in the Emergency Department, how long did you wait for a nurse to assess your priority (i.e. how long did you wait to see a triage nurse)?
B3.	Overall, did you think the patient priority system was fair?
B4.	Following your arrival in the Emergency Department, how long did you wait before being examined by a doctor or nurse practitioner?
B6.	Overall, how long did your visit to the Emergency Department last?

Safe, high quality, coordinated care	
C6.	Did you have confidence and trust in the doctors and nurses examining and treating you?
C7.	In your opinion, did the doctors and nurses in the Emergency Department know enough about your condition or treatment?
D6.	Sometimes in a hospital, a member of staff will say one thing and another will say something quite different. Did this happen to you in the Emergency Department?
H6.	Did a member of staff tell you about what danger signals regarding your illness or treatment to watch for after you went home?

Better information, more choice	
C2.	While you were in the Emergency Department, did a doctor or nurse explain your condition and treatment in a way you could understand?
D3.	While you were in the Emergency Department, how much information about your condition or treatment was given to you?
D7.	Were you involved as much as you wanted to be in decisions about your care and treatment?
E3.	Did a member of staff explain the results of the tests in a way you could understand?

Building relationships

C1. Did you have enough time to discuss your health or medical problem with the doctor or nurse?

C3. Did the doctors and nurses listen to what you had to say?

C5. If you had any anxieties or fears about your condition or treatment, did a doctor or nurse discuss them with you?

C8. Did doctors or nurses talk in front of you as if you weren't there?

Clean, comfortable, friendly place to be

D4. Were you given enough privacy when discussing your condition or treatment?

D5. Were you given enough privacy when being examined or treated?

F5. Do you think the hospital staff did everything they could to help control your pain?

G1. In your opinion, how clean was the Emergency Department?

J1. Overall, did you feel you were treated with respect and dignity while you were in the Emergency Department?

Appendix 3: Scoring of individual indicator questions
Outpatients

A1. Overall, from the time you were first told you needed an appointment to the time you went to the Outpatients Department, how long did you wait for an appointment?	
Up to 1 month	100
More than 1 month but no more than 3 months	80
More than 3 months but no more than 5 months	60
More than 5 months but no more than 12 months	40
More than 12 months but no more than 18 months	20
More than 18 months	0
I went to Outpatients without an appointment	Missing
Don't know/ Can't remember	Missing

A2. Before your appointment, did you know the reason for the appointment?	
Yes, definitely	100
Yes, to some extent	50
No	0

A3. Before your appointment, did you know who to contact if your symptoms or condition got worse?	
Yes	100
No	0

A4. Was your appointment changed by the hospital?	
No	100
Yes, once	67
Yes, 2 or 3 times	33
Yes, 4 times or more	0

B1. How long after the stated appointment time did the appointment start?	
Seen on time, or early	100
Waited up to 5 minutes	83
Waited 6 - 15 minutes	67
Waited 16 - 30 minutes	50
Waited 31 - 60 minutes	33
Waited more than 1 hour but no more than 2 hours	17
Waited more than 2 hours	0
Don't know/Can't remember	Missing

B2. Were you told how long you would have to wait?	
Yes, but the wait was shorter	100
Yes, and I had to wait about as long as was told	100
Yes, but the wait was longer	50
No, I was not told	0
Don't know/ Can't remember	Missing

B3. Were you told why you had to wait?	
Yes	100
No, but I would have liked an explanation	0
No, but I didn't mind	50
Don't know/ Can't remember	Missing

C1. In your opinion, how clean was the Outpatients Department?	
Very clean	100
Fairly clean	67
Not very clean	33
Not at all clean	0
Can't say	Missing

C2. How clean were the toilets at the Outpatients Department?	
Very clean	100
Fairly clean	67
Not very clean	33
Not at all clean	0
I did not use a toilet	Missing

D2. Did you have enough time to discuss your health or medical problem with the doctor?	
Yes, definitely	100
Yes, to some extent	50
No	0

D4. Did the doctor explain the reasons for any treatment or action in a way that you could understand?	
Yes, completely	100
Yes, to some extent	50
No	0
I did not need an explanation	Missing
No treatment or action was needed	Missing

D5. Did the doctor listen to what you had to say?	
Yes, definitely	100
Yes, to some extent	50
No	0

D7. If you had important questions to ask the doctor, did you get answers that you could understand?	
Yes, definitely	100
Yes, to some extent	50
No	0
I did not need to ask	Missing
I did not have an opportunity to ask	0

D8. Did you have confidence and trust in the doctor examining and treating you?	
Yes, definitely	100
Yes, to some extent	50
No	0

D9. Did the doctor seem aware of your medical history?	
He/she knew enough	100
He/she knew something but not enough	50
He/she knew little or nothing	0
Don't know/ Can't say	Missing

E3. If you had important questions to ask him/her, did you get answers that you could understand?	
Yes, definitely	100
Yes, to some extent	50
No	0
I did not need to ask	Missing
I did not have an opportunity to ask	0

E1. Did you have confidence and trust in him/her?	
Yes, definitely	100
Yes, to some extent	50
No	0

F3. Did doctors and/or other staff talk in front of you as if you weren't there?	
Yes, definitely	0
Yes, to some extent	50
No	100

F4. While you were in the Outpatients Department, how much information about your condition or treatment was given to you?	
Not enough	50
Right amount	100
Too much	50
I was not given any information about my treatment or condition	0

F6. Were you involved as much as you wanted to be in decisions about your care and treatment?	
Yes, definitely	100
Yes, to some extent	50
No	0

G4. Did a member of staff explain the results of the tests in a way you could understand?	
Yes, definitely	100
Yes, to some extent	50
No	0
Not sure/ Can't remember	Missing
I was told that the results of the tests would be given to me at a later date	Missing
I was never told the results of the tests	0

J1. How well organised was the Outpatients Department you visited?	
Not at all organised	0
Fairly organised	50
Very well organised	100

J2. Overall, did you feel you were treated with respect and dignity while you were at the Outpatient Department?	
Yes, all of the time	100
Yes, some of the time	50
No	0

Appendix 4: Scoring of individual indicator questions
Emergency

B1. Following your arrival in the Emergency Department, how long did you wait for a nurse to assess your priority (i.e. how long did you wait to see a triage nurse)?	
I did not have to wait to be assessed	100
1 - 15 minutes	75
16 - 30 minutes	50
31 – 60 minutes	25
More than 60 minutes	0
Don't know/ Can't remember	Missing
I left before I was assessed	0

B3. Overall, did you think the patient priority system was fair?	
Yes	100
No	0
Can't say/ Don't know	Missing

B4. Following your arrival in the Emergency Department, how long did you wait before being examined by a doctor or nurse practitioner?	
I did not have to wait	100
1 - 30 minutes	80
31 - 60 minutes	60
More than 1 hour but no more than 2 hours	40
More than 2 hours but no more than 4 hours	20
More than 4 hours	0
Can't remember	Missing
I did not see a doctor or a nurse practitioner	Missing

B6. Overall, how long did your visit to the Emergency Department last?	
Up to 1 hour	100
More than 1 hour but no more than 2 hours	83
More than 2 hours but no more than 4 hours	67
More than 4 hours but no more than 8 hours	50
More than 8 hours but no more than 12 hours	33
More than 12 hours but no more than 24 hours	17
More than 24 hours	0
Can't remember	Missing

C1. Did you have enough time to discuss your health or medical problem with the doctor or nurse?	
Yes, definitely	100
Yes, to some extent	50
No	0
I did not see a doctor or a nurse	Missing

C2. While you were in the Emergency Department, did a doctor or nurse explain your condition and treatment in a way you could understand?	
Yes, completely	100
Yes, to some extent	50
No	0
I did not need an explanation	Missing

C3. Did the doctors and nurses listen to what you had to say?	
Yes, definitely	100
Yes, to some extent	50
No	0

C5. If you had any anxieties or fears about your condition or treatment, did a doctor or nurse discuss them with you?	
Yes, completely	100
Yes, to some extent	50
No	0
I didn't have anxieties or fears	Missing

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

C7. In your opinion, did the doctors and nurses in the Emergency Department know enough about your condition or treatment?	
All of them knew enough	100
Most of them knew enough	67
Only some of them knew enough	33
None of them knew enough	0
Don't know/ Can't say	Missing

C8. Did doctors or nurses talk in front of you as if you weren't there?	
Yes, definitely	0
Yes, to some extent	50
No	100

D3. While you were in the Emergency Department, how much information about your condition or treatment was given to you?	
Not enough	50
Right amount	100
Too much	50
I was not given any information about my treatment or condition	0

D4. Were you given enough privacy when discussing your condition or treatment?	
Yes, definitely	100
Yes, to some extent	50
No	0

D5. Were you given enough privacy when being examined or treated?	
Yes, definitely	100
Yes, to some extent	50
No	0

D6. Sometimes in a hospital, a member of staff will say one thing and another will say something quite different. Did this happen to you in the Emergency Department?	
Yes, definitely	0
Yes, to some extent	50
No	100

D7. Were you involved as much as you wanted to be in decisions about your care and treatment?	
Yes, definitely	100
Yes, to some extent	50
No	0
I was not well enough to be involved in decisions about my care	Missing

E3. Did a member of staff explain the results of the tests in a way you could understand?	
Yes, definitely	100
Yes, to some extent	50
No	0
Not sure/ Can't remember	Missing
I was told that the results of the tests would be given to me at a later date	Missing
I was never told the results of the tests	0

F5. Do you think the hospital staff did everything they could to help control your pain?	
Yes, definitely	100
Yes, to some extent	50
No	0
Can't say/ Don't know	Missing

G1. In your opinion, how clean was the Emergency Department?	
Very clean	100
Fairly clean	67
Not very clean	33
Not at all clean	0
Can't say	Missing

H6. Did a member of staff tell you about what danger signals regarding your illness or treatment to watch for after you went home?	
Yes, completely	100
Yes, to some extent	50
No	0
I did not need this type of information	Missing

J1. Overall, did you feel you were treated with respect and dignity while you were in the Emergency Department?	
Yes, all of the time	100
Yes, some of the time	50
No	0

Appendix 5: Mean and standard deviation, all domains, both surveys

Outpatients

National Proportions

Males 16-35	0.035214926
Males 36-50	0.062095873
Males 51-65	0.125385474
Males 66+	0.194267903
Females 16-35	0.077713793
Females 36-50	0.115592497
Females 51-65	0.166458501
Females 66+	0.223271031

Means (Standard Deviations) for z-scores:

Access & waiting	76.9624 (2.57384)
Safe, high quality, coordinated care	84.1197 (3.09856)
Better information, more choice	84.9645 (2.16115)
Building relationships	87.1753 (2.05855)
Clean, comfortable, friendly place to be	75.2845 (5.07942)

Emergency

National proportions:

Males 16-35	0.129529736
Males 36-50	0.116390753
Males 51-65	0.11234929
Males 66+	0.119383803
Females 16-35	0.148959196
Females 36-50	0.115680538
Females 51-65	0.108290917
Females 66+	0.149415763

Means (Standard Deviations) for z-scores:

Access & waiting	67.7829 (5.98950)
Safe, high quality, coordinated care	79.3692 (3.76288)
Better information, more choice	78.8013 (3.65932)
Building relationships	80.5498 (3.09852)
Clean, comfortable, friendly place to be	81.7451 (4.39188)

NHS National Patient Survey Programme: data weighting issues

1. Introduction

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

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

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

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

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

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

2. Samples

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

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

Table 1 Summary of sampling methods

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

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

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

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

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

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

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

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

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

3. Weighting the results

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

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

4. Illustrative example

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

Table 2 Students and smoking

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

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

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

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

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

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

5. Weighting for national level patient survey estimates

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

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

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

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

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

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

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

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

Table 3 Weighting to trust population

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

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

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

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

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

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

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

Estimate = 340.6667 / 1400 = 0.2433

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

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

Dealing with missing data and filtered questions

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

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

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

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

What weight should be used?

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

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

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

Calculating patient population weights

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

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

where:

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

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

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

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

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

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

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

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

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

Patten Smith
4 November 2005

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

NHS PATIENT SURVEY PROGRAMME

ACUTE TRUSTS: EMERGENCY DEPARTMENT PATIENT SURVEY 2003

About the survey

The Emergency Department Survey 2003 is part of the NHS Patient Survey Programme, initiated by the Department of Health and now the responsibility of the Commission for Health Improvement (CHI). Over 59,000 patients from 155 NHS trusts in England participated in this survey. The survey was designed to provide actionable feedback to each participating trust on patients' views of the care they had received in emergency departments, as well as providing CHI with patient focused indicators to feed into the 2003 performance ratings for acute and specialist NHS trusts. Further details of the survey methodology can be found in the separate note on the website.

About the benchmarking reports

Each report presents question level results for an individual trust.

The emergency department core questionnaire contained 47 precoded questions, 35 of which could be evaluated as an indicator of performance. These 35 questions were allocated to one of the five domains of patient experience used by the Department of Health:

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

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

For each question, the individual patient responses were scored on a scale of 0 to 100, depending on the extent to which the patient's experience could have been better. 100 represents the best possible response. The scoring used for each question can be found on the scored questionnaire on the website.

The mean performance score on each question was calculated at both the national level (across all trusts) and for each trust in the survey, weighted by the age and sex of respondents. The trust level results are standardised, so that their age sex profile reflects the national age sex distribution (based on all of the survey respondents). This is so that results can be compared between trusts with different patient profiles.

Interpreting the charts

Each bar represents the range of performance scores across all trusts for one question.

The bar is divided into three coloured segments:

- the left hand end of the bar (coloured red) shows the 'worst' performance scores, representing the 20% of trusts with the lowest scores

- the right hand end of the bar (coloured green) shows the 'best' performance scores, representing the 20% of trusts with the highest scores

- the middle section of the bar (coloured orange) represents the range of scores achieved by the remaining 60% of trusts

The performance score for an individual trust is shown on each bar by a yellow diamond, with 95% confidence intervals shown by the black lines extending to either side.

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

Interpreting the tables

The table shows the performance scores on each question, grouped within the five domains. The first column of results are the scores for this trust, followed by their confidence intervals.

The next column relates to the best 20% of trusts on each question and shows the threshold scorefor this group i.e. the value which must be reached if a trust is to be within the best 20% of trusts. The next column shows the highest score achieved, across all trusts, on each question.

The final column shows the number of respondents on each question for this trust. Some questions were not asked of all patients; where fewer than 30 patients at a trust answered a question, the results are not shown.

The second table in this report gives some background information about the patients surveyed at this trust and nationally, including demographic profiles, the number of patients who returned completed questionnaires and the response rates.

Further information

Full details of the survey methodology can be found at:
http://www.nhssurveys.org/docs/Emergency_Guidance_V12b.pdf

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

More information on the 2002 / 2003 NHS performance ratings is available on the CHI website (www.chi.nhs.uk/ratings).

NHS trust-based patient surveys:
acute hospital trusts
Emergency Departments

Last updated 14 March 2003

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

http://www.nhssurveys.org

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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.)

Outpatients Survey

Acute NHS Trusts will also be required to carry out a survey of Outpatients Departments in 2002/03. A separate guidance manual, questionnaire and question bank for the outpatients survey is available from the NHS Survey Advice Centre website. The main difference in the methods to be used in these surveys is in the sampling instructions.

Changes to the procedures outlined in this document

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

Please direct questions or comments about this guidance to:

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CONTENTS

1 Introduction: patient feedback and the NHS Plan

1.1 The Commission for Health Improvement

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

1.2 Why we need patient feedback

Quality in health and medical care has two distinct dimensions. One has to do with the quality of care assessed by professional standards, clinical outcomes, and technical measures. The other dimension concerns the quality of the patient's experience, and this can only be assessed by patients themselves. It is important to adopt systematic, appropriate and effective ways to ask patients about their experiences, and use this information to shape and improve the way health care is delivered. This manual is designed to help staff in acute NHS Trusts to obtain patient feedback and use the information in quality improvement programmes and for monitoring purposes. By following this guidance, you will also help to ensure that the survey results from your trust are comparable with other trusts, and with national benchmarks.

1.3 Patient feedback and the NHS Plan

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

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

- Providing information to support local quality improvement initiatives
- Tracking changes in patient experience locally over time
- Providing information for active performance management
- Providing information to support public and parliamentary accountability.

1.4 Performance indicators

Information drawn from the Basic Emergency Survey questions will be used by CHI to create headline NHS Performance Indicators. These patient focus indicators will be published as part of the headline Performance Indicators set in summer 2003. Some of the patient focus indicators will also be used in Acute and Specialist Trust Performance Ratings, also due for publication in summer 2003.

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

1.5 Basic requirements for NHS Trust Emergency Department Surveys

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

- You must contact the Survey Advice Centre by 31st January 2003 and tell them who is carrying out your survey (i.e. whether it will be carried out by an approved contractor or in-house), and who in your trust will be responsible for monitoring survey's progress (e-mail: emergency.data@pickereurope.ac.uk).
- A postal questionnaire survey must be carried out.
- The questionnaire must be sent to 850 adults who have attended emergency departments in the trust within the month selected.
- The sample of patients must be a random sample of patients taken from all patient attendances in one month. (The month should be November 2002 or January 2003)
- The questionnaire must include the 47 Basic Emergency Survey questions. See 11.1 - *The Basic Emergency Survey.*
- The response rate must be at least 60%. That is, you must get 500 returned questionnaires from the 850 mailed out. Three mailings will be necessary to achieve this target.
- The data from the Basic Emergency Survey questions, and information about the patient sample, must be submitted to the Survey Advice Centre in the form outlined in 13.4 - *Supplying data to the Survey Advice Centre* by 30th April 2003.

1.6 How to use this guide

Trusts have the option of conducting the survey in house or using an approved contractor (see Section 4). Whichever route you take, you will need to address the guidance in Sections 1 to 11 and 14 to 15 of this guide. Sections 12 and 13 cover the practicalities of mailing out the survey, following-up responses and processing the results. These sections will be most relevant to approved contractors, or trusts undertaking the surveys themselves.

2 Setting up a project team

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

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

3 Approved Survey Contractor versus in-house surveys

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

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

3.1 Costs

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

Staff time

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

Consumables

First mailing

You will need 850 of each of the following items:

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

Second mailing (first reminder)

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

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

Third mailing (second reminder)

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

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

FREEPHONE service

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

FREEPOST licence

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

Data entry

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

Design and production of reports

This requires a considerable amount of skilled staff time.

3.2 Quality and confidence in the findings

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

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

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

3.3 Timing

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

3.4 Human resources

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

- Administration of postal surveys
- Communication and coordination of multi-disciplinary teams
- Data entry, validation and cleaning using proprietary data management/analysis software, such as Microsoft Excel or Access for Windows, EpiInfo or SPSS for Windows
- Data analysis and interpretation
- Report writing

3.5 Comparing departments or hospitals within your trust

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

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

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

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

4 Commissioning a survey from an Approved Contractor

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

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

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

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

http//:www.nhssurveys.org

Ipsos-RSL

Contact: Sam McGuire

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

Maritz

Contact: Dr. Matt King

Director of Public and Social Research
Maritz Research
Seagate House
Globe Park
Marlow
SL7 1LW

Tel: 01628 895 479
Fax: 01628 478 869
E-mail: mking@maritz.co.uk

Market Research UK

Contact: Craig Taylor; Jo Cleaver; Rachel Cope

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

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

Marketing Sciences

Contact: Eileen Sutherland

Marketing Sciences
8 Clement Street
Winchester
Hants
SO23 9DR

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

Market & Opinion Research International (MORI)

Contacts: Tim Jennings, Mark Gill

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

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

MSB Ltd

Contact: Stephen Harwood

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

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

NFO System Three

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

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

NOP

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

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

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

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

ORC International

Contact: Geraldine Bailey

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

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

Patient Dynamics

Contact: Andrew Smith

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

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

Picker Institute Europe

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

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

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

PricewaterhouseCoopers

Contact: Dave Ingram, National Project Coordinator – Patient Surveys

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

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

Quality Health

Contact: Dr Reg Race

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

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

Taylor Nelson Sofres

Contact: Susannah Quick or Christine Jamieson

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

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

Contracts

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

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

5 Data protection and confidentiality

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

5.1 Caldicott

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

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

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

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

5.2 Sending out questionnaires

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

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

1. The contractor delivers pre-packed serial-numbered envelopes containing questionnaires, covering letters and FREEPOST envelopes to the trust. The trust then attaches number-matched address labels to the envelopes and sends them out to patients. Completed questionnaires can then be returned to the contractor and, by checking the Patient 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 Chapters 9 and 12.

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

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

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

5.3 Sample Honorary Contract

[Name of NHS Trust]

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

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

FORM OF ACCEPTANCE

I hereby accept the terms and conditions set out above.

Signed: …… Date:……..

[Name of employee]

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

[NHS Trust]

13. Date:……..

5.4 Patient confidentiality

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

5.5 Patient anonymity

In-house surveys

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

Approved Contractors

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

5.6 Storing completed questionnaires

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

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

6 Ethical issues and ethics committees

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.

Seeking ethical approval

CHI has obtained ethical approval for the Basic Emergency Survey, the question bank, the covering letter and the reminder letter, all of which are now downloadable from the NHSsurveys website.

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

New questions or different methodology

If you write your own questions, or design your own research for a different project, you will need to obtain ethical approval from the Local Research Ethics Committee (LREC) before you proceed. The LREC will want to see the letter from the MREC and any additional documents relating to the changes you intend to make. This process may take at least 2 months. The relevant MREC documents are available from the NHSsurveys website.

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

7 Collecting data from non-English-speaking populations

The patients who respond to your survey should be representative of all of the patients who use the Trust, so it is important that groups with limited understanding of English are not excluded. However, for these Emergency Department Surveys, it is not permissible to translate questionnaires. At least for the 2003 survey, there would not be adequate time to check that all translations were accurate, and to carry out the necessary validation checks. Furthermore, we do not recommend translation of questionnaires as the most effective way of obtaining feedback from minority language groups. In considering this issue, it is worth noting the following points:

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

- The Basic Emergency Survey and the question bank have been written in as **simple language** as possible to facilitate optimum understanding by all respondents. The questions have also been tested with patients from a range of ethnic groups.

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

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

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

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

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

- Translating the questionnaire is not a feasible option, at least for the 2003 Emergency Department Surveys. However, for other surveys, you might consider translating questionnaires into the languages of minority groups who use your Trust. It should be noted that translating a questionnaire involves a considerable amount of staff time and expense.

- There is a risk when translating any document that the ideas contained in the original document are not accurately represented in the other languages. In any case, once a document has been translated by one person, a different person should translate it back into English. Refinements to the wording can then be made where the back-translation differs from the original document. The translation and back-translation process needs to be repeated until discrepancies between the two documents are minimal. For the 2003 Emergency Department Surveys, there is not enough time to carry out the validation procedures necessary to translate a survey.

8 Timetable

The length of time taken to complete the survey process will depend on many factors. Assuming no delays in drawing the patient sample, it is reasonable to allow about 12 weeks from start to finish, i.e. from drawing the sample to receiving the final report. Dissemination of the results to all staff could take considerably longer than this.

The following timetable is based on the *minimum* expected duration of each stage. If you commission an Approved Contractor, most of the work will be done by them, but you will still have to be involved in some of the stages of the process, marked in **bold** in the timetable below.

Timetable

Week	Task	See Section
1	**Draw sample of patients to be included in the survey**	9
1	**Submit sample list to Tracing Service to check for deceased patients**	9.5
1	**Inform Survey Advice Centre about who is carrying out the survey (by 31st Jan 2003 at the latest).**	3
2	**Decide on questions to be included in the survey (i.e. select from question bank or use a Basic Emergency Survey)**	11
2	Print questionnaires and covering letters	12.2&12.3
2	Ensure you have enough envelopes, return envelopes and labels	12.2
2	Set up FREEPOST address and FREEPHONE (optional)	12.1&12.4
2	Establish system for responding to telephone enquiries	12.4
3	Establish system for booking in questionnaires	12.6
3	Send out first questionnaires	12.5
3 - 8	**Stick labels on pre-packed numbered questionnaires supplied by approved contractor**	
3-12	Continue responding to telephone enquiries	
3-12	Continue to book in returned questionnaires	
3-12	Enter data	13
5-6	Send out first reminders to non-responders	12.7
5-6	Be prepared for a small peak in telephone calls as people receive first reminder	
8	Send out second reminders to non-responders	12.7
11	Complete data entry	
11	Check data for errors	13.3
12	Send data to Survey Advice Centre (by 30th April 2003 at the latest)	13.4
12	Begin analysing trust's results and writing report	14&15

9 Compiling a list of patients

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

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

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

9.1 Compile a full list of patient attendances in 1 month

- Select the month of Emergency Department attendances that your survey will cover. Depending on when you start, this should be **either** November 2002 **or** January 2003. (December should be avoided, as it tends to be atypical.)

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

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

What to leave out

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

- Any attendances at **Minor Injuries Units**

- Any patients who were admitted to hospital via **Medical or Surgical Admissions Units**

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

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

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

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

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

9.2 Data fields to include in the list of visits

The list should contain the following information:

- Patient Record Number [1]
- Title (Mr, Mrs, Ms, etc.)
- Initials (or First name)
- Last name
- Address Fields [2]
- Postcode
- Year of birth
- Gender
- Ethnic category [3]
- Date of arrival at the Emergency Department
- Survey unit – e.g. hospital site [4] - **Optional**
- Any other details required by the NHS Strategic Tracing Service (NSTS). [5]

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

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

[3] It is acknowledged that patient records for the Emergency Department 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 CHI and Department of Health to be more responsive to all ethnic groups and provide services that take account of their individual requirements.

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

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

9.3 Taking a sample

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

Note: You are aiming for **a response rate of at least 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. It is **not** acceptable to try to boost the number of responses you receive by sending out questionnaires to a larger number of patients. The Survey Advice Centre will only be able to accept responses from the 850 patients in your list that have been correctly sampled.

In order to select the 850 patients to be included in your sample, you need to take a **random sample** of 850 patients from your full list. The procedure for doing this is as follows:

1. Put the list of attendances into an electronic file in a programme that allows sorting by columns (for example, Microsoft Excel or Access).

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

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

4. Calculate **n:** the fraction of patient attendances you will need to extract from the total number of attendances, in order to select 850 patients (See example below).

Example

Number of Emergency Department attendances at your trust in one month = 25,000

Fraction of full list you need to extract = 25,000 ÷ 850 = **29.4**

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

6. Create a new data column in your patient file (call this column '**fraction**'). Fill this column with a repeating series of numbers, starting with 1 in the first row and then numbering each record consecutively through to **29** (remember to use your own value of **n**).

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

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

   If you are using Excel, it might be easiest to sort the data by the new column 'fraction' and then delete all the rows above and below those with **14** in the fraction column (N.B. Ensure that you select all the columns before sorting in Excel, otherwise the patient details will get mixed up).

9. This will give you a list of patients consisting of every **n**th record from the original list. This should be at least 850 records, but may be slightly more. Save this sample into a new file (keeping the initial sample list in another file, in case you need to return to it later).

9.4 Check the sample list

Once you have compiled your list of 850 patients, it is important to carry out a few final checks before sending the data to the NSTS:

- **Duplications.** You should check your list to make sure patients' names do not appear more than once, and you should remove any duplicated names. [6]

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

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

- **Incomplete information.** Check for any records with incomplete information on key fields (such as surname and address) and remove those patients. However, do not exclude anyone simply because you do not have a postcode for them.

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

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

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

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

Before sending out the questionnaires, the list of patients will also have to be checked for any deceased patients by the NHS Strategic Tracing Service (NSTS). NSTS update their information about every 7 days, so you can increase accuracy by asking them for a check shortly after one of these data updates.

The NSTS contact details are as follows:

Help desk telephone number: 0121 788 4001

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

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

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

Note: Please be aware that tracing services are not fool-proof and even after your patient list has been checked for deaths, some patients may die in the period between running the NSTS 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.

Note from SchlumbergerSema (NSTS Partner)

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

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

The full details are given in the new instruction manual:

SchlumbergerSema NHS Patient Survey File Creation Guide

This is available on the NHSsurveys website.

The basic requirements are:

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

9.6 Number of patients in final list

Too many patients in the list

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

Too few patients in the list

You are required to achieve a **60% response rate,** and to obtain completed questionnaires from at least 500 patients. Therefore, to achieve the required number of responses you need to send out questionnaires to a minimum of 833 patients. (The figure 850 allows for a few extra patients.) If you have fewer than 833 patients in your final list, you might want to consider carrying out the patient sampling procedure again. (If necessary, call the Survey Advice Centre for further advice on this.)

9.7 Organise the patient information into the sample file

- It would be helpful to the Survey Advice Centre team if you sent this file to them as soon as it is ready but, in any case, it should be sent in an anonymised form by **30th April 2003** at the latest (See 13.4 - *Supplying data to the Survey Advice Centre* for details of how to do this).

Table 1 shows part of an example Excel file comprising patient details.

Table 1 – Sample Excel file of patient details

Patient Record Number	Title	Initials	Lastname	Address1	Address2	Address3	Address4	Postcode	Year of birth	Gender	Ethnic Category	Date of attendance	Comments	Outcome
1001	Mrs	AM	Abbot	Upper Flat	24, West Rd	Town name	County	AB1 1YZ	1925	2	1	09/11/2002	Informed Patient died	4
1002	Mr	EC	Ahmed	1, Field Drive	Town name	County		AB2 6XZ	1937	1	3	14/11/2002		1
1849	Miss	K	Yoo	54, Cross St	Town name	County		AB4 7MX	1965	2	5	21/11/2002		
1850	Ms	F	Young	31a Main Road	Town name	County		AB9 5ZX	1941	2	1	08/11/2002		1

- It can be seen that the **Patient Record Numbers** are in ascending order, starting at 1001 at the top of the list. The sampled attendances are numbered consecutively, through to 1850 at the bottom of the list. This Record number is unique for each patient. It is printed on the questionnaires and on the address labels and can be used to identify which patients have returned their surveys. If an approved contractor is used, you will need to agree with them on the range of serial numbers that will be used for your patients.

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

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

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

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

- **Ethnic category** should be coded using the broad categories 1 = White; 2 = Mixed; 3 = Asian or Asian British; 4 = Black or Black British; 5 = Chinese; 6 = any other ethnic category. These are based on the standard categories introduced by the NHS Information Authority from 1st April 2001.

- The **Date of attendance** (in the form DD/MM/YYYY) is included as it can be used to check the actual sampling period used by the trust.

Additional fields

You also need to add two additional data columns:

- 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. This column is left blank if the survey has not been returned (so it can be seen that Miss Yoo has not yet returned her survey); 1 = returned useable questionnaire, (Mr Ahmed and Ms Young have returned their surveys); 4 = patient died (Mrs Abbott's relative called to say that she had died).

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

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

10 Maximising patients' receptiveness to the survey process

The following procedures will be necessary to increase response rates and reduce the number of questions and complaints about a survey.

Establish a process for answering questions and handling complaints

- Survey managers should have contact details of patient liaison staff or complaints managers, so that they can guide patients to the correct services if they contact them about matters not related to the survey.

- You might want to set up a dedicated telephone line, or FREEPHONE line that patients can call with any questions they might have about the survey.

- Patients can be expected to call doctors, nurses, patient liaison officers, Emergency Departments, or the Chief Executive's office with questions about the survey, even when your covering letters give contact details for the survey managers. Notify front line staff and executive offices that a survey is being conducted, and give them the name and number of a contact person. Survey managers should be prepared to respond to these calls quickly.

Publicise the survey

- Heighten awareness of the survey and the importance the trust places on patient feedback through posters in the hospital and communications with patients after their attendance, and in community newsletters. Also, it is sometimes a good idea to send a press release to the local media to gain publicity before the survey takes place.

11 The Basic Emergency Survey questions and question bank

Each trust must include in their survey at least the 47 Basic Emergency Survey questions. There is a pre-designed questionnaire on the NHSsurveys website, which includes only these questions. In addition, by using the "Create your own survey" option on the website, you can include supplementary questions from a bank of validated questions. These questions will be inserted into the appropriate places in the Basic Emergency Survey questionnaire, and the document will then be generated in .pdf format, ready for printing.

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

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

1. The **Basic Emergency Survey**, which comprises 47 core questions.

2. The **Enhanced Survey**, which includes all of the 47 Basic Emergency Survey questions, with an additional bank of validated questions.

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

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

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

The surveys can be accessed from the NHSsurveys website:

http://www.nhssurveys.org

11.1 The Basic Emergency Survey

The Basic Emergency Survey consists of 47 questions on 8 pages. These 47 questions cover the issues that have been found to be most important to patients and they must be included in your survey. The front page of the survey explains the purpose of the survey and gives instructions on how to fill it in. In the following pages, the survey questions are divided into sections that broadly follow the patient's experience.

11.2 Using the question bank

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

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

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

11.3 The Customised Survey

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

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

12 Implementing the survey-practicalities

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

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

12.1 Setting up a FREEPOST address

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

http://www.royalmail.com

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

12.2 Printing questionnaires

Number of pages

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

Number of questionnaires

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

12.3 Covering letters

The following covering letter has been given ethical approval for use in the NHS Trust Emergency Department Surveys. It should be printed on the trust's letterhead paper. If you make any substantial alterations to it, you will need to seek the approval of your local research ethics committee (LREC).

Covering letter

To be printed on Trust headed notepaper. Text in square brackets needs to be edited.

[Date]

Dear Patient

Re: Emergency Department (A&E) survey

You are invited to take part in a survey of patients visiting the Emergency Department[s] (A&E/Casualty) [at Hospital A] or [Hospital B] of the [NHS Trust name]. This survey is part of our commitment, outlined in the NHS Plan, to design a health service around the patient. We are asking you to give us your views by filling in the enclosed questionnaire. The questionnaire should only take about 20 minutes to complete. A freepost envelope is enclosed.

Your views are very important in helping us to find out how well the Emergency Departments work and how they can be improved. This is your chance to have a say in how services are provided in the future. You are being invited to take part in this survey because you recently visited the Emergency Department at [NHS Trust name]. We are sending similar questionnaires to 850 people who visited the department[s] in [month].

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

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

If you would like more information about the survey, or you have questions on how to complete the questionnaire, please do not hesitate to contact [our FREEPHONE/us] on **[phone number]** [at no cost to yourself]. The line is open between [opening time] and [closing time], Monday to Friday and we will try our best to answer any questions you may have.

Yours faithfully

Chief Executive [or similar]

[NHS Trust name]

12.4 Setting up a FREEPHONE line

The covering letter to patients should include a telephone number for patients to call if they have any questions or complaints about the survey. You might want to set up a FREEPHONE line for this purpose. All staff who are likely to take calls should be properly briefed about the details of the survey, and be aware of the questions or complaints they are likely to receive.

Common questions and comments

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

Patients should be advised to refer only to the hospital emergency department visit covered by the month selected by you at the trust named on the questionnaire/ covering letter. Usually, this is their most recent visit.

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

Patients can be referred to the trust's PALS, the complaints manager or patient services manager.

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

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

The person to whom the questionnaire is addressed has died.

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

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

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

I do not wish to participate in this survey.

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

Making a record of the calls

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

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

12.5 Sending out questionnaires

Mailing labels

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

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

Questionnaire packs

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

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

These items should be packed into an envelope that has a return address on the

outside. This should be the contact at the NHS Trust, or the Approved Contractor.

Postage

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

Approved contractors

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

12.6 Booking in questionnaires

When questionnaires are received, match up the Patient Record Numbers against the list of patients, so that you can record which patients have returned questionnaires and will not therefore need to be sent reminders.

Approved contractors

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

12.7 Sending out reminders

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

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

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

Approved contractors

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

First reminders

CHI has obtained ethical approval for the reminder letter printed below. This is downloadable from the NHSsurveys website. If you make any substantial alterations to it, you will need to seek the approval of your local research ethics committee (LREC).

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

First reminder

Text in square brackets needs to be edited

[Date]

[Name of NHS Trust]

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

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

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

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

Second reminders

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

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

A sample of the second reminder letter is printed below:

Covering letter for second reminder

To be printed on Trust headed notepaper. Text in square brackets needs to be edited.

[Date]

Dear Patient

Re: Emergency Department (A&E) survey

Enclosed is a copy of a patient survey about your visit to the Accident & Emergency Department of [Hospital A] or [Hospital B] of the [NHS Trust name]. We originally sent the survey to you a few weeks ago. **Your views are very important in helping us to find out how well the Accident & Emergency Departments work and how they can be improved**, so we would like to hear from you. If you have already replied, please ignore this letter and accept our apologies.

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

You have been invited to take part in a survey because you recently visited the Emergency Department at [NHS Trust name]. We are sending similar questionnaires to 850 people who visited the department[s] in [month year]. This survey is part of our commitment, outlined in the NHS Plan, to design a health service around the patient. This is your chance to have a say in how services are provided in the future.

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

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

If you would like more information about the survey, or you have questions on how to complete the questionnaire, please do not hesitate to contact [us /our FREEPHONE] on **[phone number]** [at no cost to yourself]. The line is open between [opening time] and [closing time], [days] and we will try our best to answer any questions you may have.

Yours faithfully

[signature]

[print name of signatory]

Chief Executive [or similar]

[NHS Trust name]

12.8 Recording external events

The results of your survey may be affected by a number of external events at either the national or local level. For example, a 'flu epidemic may cause excessive pressure on beds and staff resources. Similarly, a strike by health care staff may have an unusual effect on the quality of patient care. It is important to record these events so that your results can be interpreted in the light of such influences, and when year-on-year comparisons are made, external circumstances may be taken into account.

13 Entering data

If an Approved Survey Contractor is used, they will be responsible for all of the data entry and checking, and when the survey is completed they should supply the trust with the data in an appropriate format.

13.1 Entering and coding data from the Basic Emergency Survey

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

http://www.nhssurveys.org/

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

- Each row records one patient's responses to the survey
- For each question, the small number next to the box ticked by the patient should be entered as the response
- If a response is missing for any reason, it should be coded as a dash (-).
- If two boxes are ticked (where only one should be ticked), the response should be coded as missing – i.e. as a dash (-).

13.2 Entering data from Enhanced or Customised questionnaires

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

Adapting data file for sending data to Survey Advice Centre

You will need to send the data for the 47 compulsory Basic Emergency Survey questions to the Survey Advice Centre. In order to do this, you will need to transfer those columns of data that cover the responses to those 47 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 Basic Emergency Survey. They also include the wordings of the 47 Basic Emergency Survey questions so that you can match up questions from Enhanced Surveys with the Basic Emergency Survey questions. It is essential that you check carefully that the columns of data you select from your larger data set correspond to the 47 Basic Emergency Survey questions. Further details on supplying data to the Survey Advice Centre are given in Section 13.4.

13.3 Checking the data for errors

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

1. Have the data been entered accurately? You can check this by double-entering the survey responses, and comparing the lines of data for any discrepancies. (This is a standard procedure available in many statistical computer packages.)
2. Are all the data entries valid responses for that question? For example, if a question allows three response options: "1", "2" or "3", check that your data does not include any other responses (except for "-" to represent missing data).
3. Scanned data is also likely to contain errors and must be checked.

13.4 Supplying data to the Survey Advice Centre

The NHS Trust Emergency Department Survey data must be supplied to the Survey Advice Centre for the calculation of performance indicators. Two separate files must be supplied, plus some additional information.

File 1: The original sample of patients

File format

- Microsoft Excel File (any version of the software is acceptable)
- File name should be in the form <NHSTrustName>_EmergencySample.xls
- One row of data for each respondent
- One column of data for each field listed

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

Table 2 - Data for inclusion in File 1

Field	Format	Data codes	Comments
Patient Record Number	NNNN		The unique serial number allocated to each patient by the trust or Approved Survey Contractor administering the survey
Year of birth	YYYY		
Gender	N	0 = Not known 1 = male 2 = female 9 = Not specified	
Ethnic category	N	1 = White 2 = Mixed 3 = Asian or Asian British 4 = Black or Black British 5 = Chinese 6 = Other ethnic category	Ethnic category should be included if the information is available
Date of attendance	DD/MM/YYYY		Date the patient attended Emergency Department
Outcome of sending questionnaire	N	1 = Returned useable questionnaire 2 = Returned undelivered by the mail service or patient moved house 3 = Patient reported deceased by tracing service 4 = Patient reported deceased by relatives 5 = Patient reported too ill to complete questionnaire 6 = Patient opted out or returned blank questionnaire 7 = Patient was not eligible to fill in questionnaire 8 = Questionnaire not returned (reason not known)	

N.B. To comply with Data Protection regulations, details that allow individuals to be identified must not be sent to the Survey Advice Centre.

Table 3 is an example of the columns of data you should send in File 1. Your file should have about 850 rows (one for each patient included in your sample)

Table 3 – Example of File 1 to be sent to Survey Advice Centre

Patient Record Number	Year of birth	Gender	Ethnic category	Date of attendance	Outcome
1001	1925	2	1	09/11/2002	4
1002	1937	1	3	14/11/2002	1
1849	1965	2	5	21/11/2002	8
1850	1941	2	1	08/11/2002	1

File 2: Questionnaire responses

File format

- Microsoft Excel File downloaded from NHSsurveys website
- File name should be in the form <NHSTrustName>_EmergencyResponses.xls
- One row of data for each respondent
- One column of data for each of the 47 Basic Emergency Survey questions, with columns appropriately labelled with question numbers
- Missing data [7] should be coded as a dash (-)

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

Table 4 shows the information that must be provided for each patient returning a questionnaire.

Table 4 – Data for inclusion in File 2

Field	Field format and codes	Comments
Patient Record Number	Format = NNNN	The unique serial number allocated to each patient by the trust or Approved Survey Contractor for purposes of administering the survey. **This number must match the number in File 1** – the patient sample file.
Responses to each of the 47 Basic Emergency Survey questions	Format = (N or NN) Data should be coded using the numbers next to the response boxes on the printed surveys.	Each column must be clearly headed with the question number that corresponds to the question number on your questionnaire.
Ethnic category (other)	Format = text Include up to 50 characters in this field	Where patients have written their ethnic category in one of the "other" boxes, the text of these responses should be included.

Additional information

The following information should also be provided:

- **Contact details** (telephone numbers and e-mail addresses) of at least two personnel who will be available to answer any queries about the data, and who can supply passwords where necessary
- **Two hard copies of the questionnaires** used to collect the data

Delivery

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

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

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

Date

The data must be supplied by 30th April 2003.

Checklist

Before sending your data to the Survey Advice Centre, ensure that you have included the following items:

1. Microsoft Excel File 1
2. Microsoft Excel File 2
3. Two hard copies of your questionnaire
4. Contact details of two personnel

14 Making sense of the data

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

14.1 Using the NHSSurveys website to look at results

Once you have entered the data from the Basic Emergency Survey into the Excel file on the website, the numbers and percentages of responses to each of the 47 Basic Emergency Survey questions are automatically computed and displayed on other sheets of the Excel workbook. There are ten sheets within the workbook, which correspond to ten sections of the Basic Emergency Survey. For each question, the numbers and percentages of respondents who gave each answer is shown. The number of missing responses will also be shown, as long as you have coded missing responses on the data sheet as a dash (-).

14.2 Suggestions on data analysis

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

Use the data to help pinpoint problems

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

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

"Drill down" into the data

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

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

Group similar questions together to provide summary analysis

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

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

Use statistical tests to make comparisons and subgroup analyses

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

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

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

Use patient feedback data with other data

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

15 Reporting results

15.1 Prioritising your report

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

Rank problems by their magnitude

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

Compare 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 results within your organisation

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

Compare results over time

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

Comparison with predefined goals

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

Correlation with overall measures

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

Predictive value on overall measures (regression analysis)

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

Ease of action

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

Areas of excellence

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

15.2 Writing the report

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

Gear the format to the audience

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

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

Use graphics

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

Keep the format succinct and consistent

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

Emphasise priorities clearly

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

15.3 Using patient feedback for improvement

There is always something to learn from survey results. Applying the lessons and implementing change is probably the most useful aspect of the survey process. It is also the most difficult.

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

Identify key "change agents"

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

Disseminate survey results through many outlets

- Disseminating survey results entails far more than producing and photocopying a report. Consider how to share results in training sessions, meetings, employee newsletters, executive communications, process improvement teams, patient care conferences, and other communications channels.
- Engage a multi-disciplinary team to prepare a dissemination strategy.
- Determine whether information should be shared initially with only senior-level people, or whether (and when) it should be spread wide and far.

Results that measure performance versus results that educate people

- Using surveys to measure performance can be a strong motivator for improvement, but it can also undermine morale and lead to defensive responses.
- Using survey results to educate staff may make the process of improvement slower, but it can also have a less negative effect on morale.

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 will probably need more detailed information to design your improvement effort. It can be time-consuming and expensive to gather this information on a large scale. Small follow-up surveys to selected groups of patients can provide valuable information and faster feedback.

Commission for
Health Improvement

Accident and emergency (A&E) patient survey 2003

CHI

Contents

Introduction

A vital step to improving hospitals and other health services so that they meet the needs of the patient is to ask the patients themselves what they think about the NHS. One way of doing this is by carrying out surveys of patients who have recently used health services. The Commission for Health Improvement (CHI) is responsible for carrying out national surveys of the NHS. By running these surveys across the country and publishing the results, CHI is able to provide important feedback about the experience patients have of their local health services.

During 2003 CHI carried out three national surveys asking patients across England about their experiences of accident and emergency departments (A&E), outpatients and primary care services. CHI has now published three reports summarising the key findings from the surveys and describing the patient's experiences of each of these services.

This report summarises the key findings from the survey of accident and emergency departments (A&E) and describes the experience of patients using emergency departments in today's NHS. All emergency departments who treat adults took part in the survey and we received completed surveys from nearly 60,000 recent patients.

The results of the survey and the patients experience relating to your local NHS hospital trust are available in detailed reports and can be found on the CHI website www.chi.nhs.uk/eng/surveys/nps2003/a&e.shtml

CHI's findings

The patient journey through the emergency department

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

Many emergency departments use a triage system. This is where on arrival a nurse sees the patient. The nurse can then assess their problem or injury and decide how urgently they need to receive care.

- 82% of patients who responded to the survey were assessed by a triage nurse
- 99% were examined by a doctor or nurse
- 56% of patients had tests including x-rays, ultrasounds or scans after being examined

One of the NHS targets is that 90% of patients will be treated within four hours of being in the emergency department. Of the patients who completed the survey:

- 69% spent less than four hours
- 22% spent between four and eight hours
- 5% spent between eight and 12 hours
- 4% spent more than 12 hours in A&E

At the end of their visit to the emergency department, most patients returned home (70%). About a quarter of patients (24%) were admitted into hospital and 2% were transferred to a different hospital or to a nursing home.

he remainder went to stay with a friend or relative or somewhere else.

From the survey results patients who were admitted to hospital from A&E generally spent longer in the emergency department than those who were able to return home. Of those patients who were being admitted to hospital 51% spent four hours or less in the emergency department while 74% of those who went home were discharged within four hours.

Arriving at the emergency department

On arrival at the emergency department:

- 39% of patients were seen and assessed by a triage nurse within 15 minutes
- 24% waited between 16 and30 minutes
- 11% waited between 31 and 60 minutes
- 7% patients had to wait more than one hour for this assessment

A small number of patients left the emergency department before they were assessed, while some patients (18%) did not have to wait to be assessed, they were seen straight away.

"The problem was the long wait and not knowing what was going on and when I would be seen again – from one department to the other and worrying about whether you are sat in the right waiting room."

Most patients (93%) were examined by a doctor or nurse practitioner within four hours:

> "Prioritisation was awful. The last visit I had with a broken collar bone I was there for 10 hours and then I was told to come back the next day as they were understaffed."

- 66% were examined by a doctor or nurse practitioner within one hour
- 27% waited between one to four hours to be examined
- 6% waited for more than four hours
- 1% did not see a doctor or nurse practitioner

Most patients (71%) were either: not told how long they might have to wait (58%) or had to wait longer than they had been told (13%). Sixteen percent of patients had to wait about as long as they were told and 13% had a shorter wait than they had been told.

The cleanliness of emergency departments is an important issue for patients. Nationally:

- 49% reported the emergency department to be very clean
- 42% said it was fairly clean
- 8% of patients felt the emergency department was not very clean or not at all clean

> "I could have been seen sooner as I was in extreme pain. People who did not appear to be in pain were seen hours before me."

Fewer patients were impressed with the cleanliness of the toilets.

Eleven percent of patients reported feeling bothered or threatened by other patients whilst in the emergency department.

Seeing a doctor or nurse

> "The nurse I spoke to had a good sense of humour which helped me relax and that was very important to me."

Ninety five percent of patients who saw a doctor or nurse felt complete confidence and trust or confidence to some extent in the doctors and nurses examining them. But 5% did not have any confidence and trust in the doctors and nurses.

Patients' confidence and trust in the staff partly reflects how they perceive the knowledge and competence of the staff this can include the staff's knowledge of the patient's condition or the treatment needed.

> "Medical staff were courteous and gave me time to explain my condition and problems surrounding this which was written down and duly passed on to the appropriate doctor on the ward."

Almost all patients (96%) said that doctors or nurses had listened to what they had to say, but many patients reported some issues around communication that could be improved:

- 63% felt they definitely had enough time to discuss their health or medical problem with the doctor or nurse, 30% felt they had enough time to some extent and 8% felt they did not have enough time

- 49% of patients with anxieties and fears felt they had been able to completely discuss their concerns with a doctor or nurse, 32% had discussed them to some extent and 19% did not discuss their concerns at all

- 10% thought that that staff were deliberately not telling them certain things that they wanted to know

- 10% of patients reported that different members of staff had given them conflicting information to some extent and 6% reported that this had definitely happened to them (84% did not report this problem)

- 10% of patients felt that doctors or nurses had talked in front of them, as if they weren't there to some extent and 5% reported that this had definitely happened (84% did not report this problem)

Health services should be accessible to everyone and for those who do not speak English interpreting services should be available. The results from the survey show that 2% of patients needed help with understanding English. However only 10% received help from staff in the emergency department (6% had a hospital interpreter and 4% had help from someone else on the hospital staff). Sixty one percent had help with interpretation from a relative or friend, but 30% did not have anyone to interpret for them.

Providing patients with basic information can help to alleviate anxieties and fears. It also helps to equip them to make informed choices about their care and treatment. The survey highlighted some gaps in information provided to patients:

> "The nurse who looked after me was fantastic. He really helped me and was honest about my condition. I was able to confide in him."

- 75% of patients felt they were given the right amount of information about their condition or treatment while in the emergency department, 15% felt they were not given enough information and 9% said they were not given any information at all about their condition or treatment

- 65% of patients said they completely understood the explanation given by the doctor or nurse, 27% only understood to some extent and 8% did not understand the explanation given. These figures exclude the 5% of patients who did not need an explanation

- excluding those patients (6%) who did not feel well enough to be involved in decisions about their care, 63% felt that they were involved as much as they wanted to be in decisions about their care and treatment, 27% only felt involved to some extent and 10% reported they were not involved as much as they wanted to be in these decisions

"More privacy when arriving to book into hospital. Emergency people sitting waiting can hear all your details, including address and phone number."

Privacy is also a very important issue for patients.

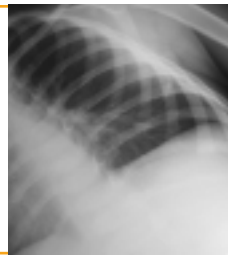
- 21% did not feel they definitely had enough privacy when they were being examined or treated
- 30% did not definitely have enough privacy when discussing their condition or treatment.

Tests and treatment

Over half (56%) of patients had tests including x-rays, ultrasounds or scans during their visit to the emergency department. Tests were performed:

- within 15 minutes for 41% of these patients
- between 16 and 60 minutes for 41% of patients
- one to two hours for 9% of patients
- more than two hours for 9% of patients

"I felt the length of time to wait for an x-ray was much too long. I arrived at 7pm and left at 3.30am. I had a four year old with me! I was waiting a long time for results and had to remind them that I was waiting and then they gave me the OK to go home."



Most patients (70%) experienced pain whilst in the emergency department. Although pain is a common experience for patients, it is important that it is managed effectively by hospital staff. Amongst those patients who experienced pain, just over half (55%) felt the hospital staff had definitely done everything they could to help control their pain. But almost one fifth of patients (18%) did not feel that staff had done everything they could and 27% felt they had to some extent.

Of those patients who experienced pain, 29% requested pain medicine. Twenty one percent of the patients who requested medication received it straight away and 22% received it within five minutes. Ten percent of the patients who asked for pain medicine were not given any.

Leaving the emergency department

Leaving a hospital can be just as daunting as entering one and patients should be given the right information to help them recover at home. The survey highlighted key areas where the information given to patients when they leave hospital could be improved:

- 37% of patients had new medications prescribed or ordered for them before leaving the emergency department. Eighty two percent felt that the purpose of the new medications had been clearly explained to them by staff, but 5% of patients reported that staff had not explained the purpose of the new medications in a way they could understand and a further 13% said their purpose had only been explained to some extent (these figures exclude those patients (7%) who said they did not need an explanation)

- 50% of patients who were given new medications reported that staff did not tell them about any side effects to watch for (figure excludes those patients (23%) who did not need information on medication side effects)

- 37% of patients who required information on the danger signals regarding their illness or treatment were not told what to watch for when they got home. A further 23% said that staff had told them about the danger signals to some extent and 40% said they had been given complete information about the danger signals (these figures exclude those patients, 36% who said they did not need this type of information)

- most patients (78%) felt they needed information on who to contact if they were worried about their condition or treatment after they got home – of these, 17% were not given this information.

A quarter of patients (24%) were admitted to the hospital, and a further 2% were transferred from a different hospital. Patients who were being admitted to hospital sometimes waited in the emergency department until being given a bed in a room or ward. Thirty percent of patients were admitted to a room or ward within one hour. Over one third of patients (35%) waited between one and four hours to get to a room or ward and 34% waited more than four hours. Almost one fifth waited between four and eight hours, 8% waited between eight and 12 hours and 7% waited for more than 12 hours to get a bed in a room or ward.

Overall

Overall, 95% of patients felt they were treated with respect and dignity whilst in the emergency department.

> "I was impressed by the care shown by all staff and the care taken to preserve one's dignity."

Nationally, 32% of patients rated the care they had received in the emergency department as excellent and 35% as very good. Eighteen percent said their care was good, but 9% rated it as fair and 5% said it was either poor or very poor.

> "All I hear on TV news about the NHS is negative – the treatment was excellent."

About CHI

What is the Commission for Health Improvement?

The Commission for Health Improvement (CHI) was established to improve the quality of patient care in the NHS. It does this by reviewing the care provided by the NHS in England and Wales (Scotland has its own regulatory body, Quality Improvement Scotland, formerly know as the Clinical Standards Board). CHI aims to address unacceptable variations in NHS patient care by identifying both notable practice, and areas where care could be improved. CHI has six operating principles that underpin all of its work:

- the patient's experience is at the heart of CHI's work
- CHI will be independent, rigorous and fair
- CHI's approach is developmental and will support the NHS to continuously improve
- CHI's work will be based on the best available evidence and focus on improvement
- CHI will be open and accessible
- CHI will apply the same standards of continuous improvement to itself that it expects of others

How was the survey undertaken?

Each trust identified a list of patients who attended a main emergency department during either November 2002 or January 2003 not including people who attended minor injuries units, medical or surgical admissions units. Staff at the hospital selected 850 patients from the list, at random. The sampled patients were sent a questionnaire and a covering letter by post and received up to two reminders.

How was the survey developed?

The questionnaire and survey methods were developed for CHI by the NHS Survey Advice Centre at the Picker Institute Europe, who carried out interviews and focus groups with patients to find out the issues, which patients considered to be most important. A full scale pilot survey was carried out in two trusts to test the questionnaire and survey methodology.

Who took part in the survey?

For the national survey, in total over 131,000 patients were sampled. Completed questionnaires were received back from 59,155 – a response rate of 46%, after allowing for some patients who proved to be ineligible. Response rates varied among trusts, from 26% to 61%.

Nationally, of all those patients who returned completed questionnaires:

- 48% were men, 52% were women
- 28% were aged 16-35, 23% were aged 36-50, 22% were aged 51-65, 19% were aged 66-80 and 7% were aged 81 or over
- 94% of respondents were White, 3% were Asian or Asian British, 2% were Black or Black British and 1% were either of mixed race or from Chinese or other ethnic groups

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