NHS Patient Surveys

Response rates for the community mental health survey

January 2016

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Contents

Summary

The response rate for the community mental health survey has historically been lower than that for other surveys within the NHS Patient Survey Programme. A low response rate leads a greater possibility of bias in survey results - hence it is a key concern for CQC and an area where action is required. Feasible attempts to improve response rates are planned for incorporation into the survey approach, to maximise response rates from all eligible service users and increase the representativeness of the survey statistics.

This evaluation looked at the response rates from a variety of subgroups within the community mental health survey: namely age, gender, ethnic group and 'care cluster' grouping.

Issues relevant to the community mental health survey include:

- Length of contact with mental health services
- People's cognitive ability to respond
- The eligible population, which may include a large proportion of people with a propensity not to respond.

Consideration must be given to the impact of changes to the survey approach, to ensure that measures to improve response have the desired effect of increasing the representativeness of the statistics (rather than encouraging more response from the groups that are known to be more likely to respond).

The proposed changes have also been reviewed in terms of timescales, to conclude what is a realistic time frame for developing, piloting and implementing new measures. Given that stakeholders and other users of the statistics often require comparable survey statistics to enable the monitoring of trends of time, consultation may be necessary where new approaches affect comparability with previous surveys.

An initial assessment of potential measures that can be applied to the 2016 community mental health survey has led to the introduction of the following actions. These will be implemented for the 2016 community mental health survey:

- Revised cover letters to encourage people to respond (completed)
- Revised guidance and materials sent to trusts to encourage them to publicise the survey to service users (completed).
- Using social media to encourage service users to respond as well as user groups and other bodies to send similar messages out, as an endorsement (from February 2016 onwards, throughout the fieldwork of the survey).
- Making use of the CQC regional communications teams and their established relationships with trusts, to encourage trusts to publicise the survey, both before and during fieldwork (from February 2016 onwards).

We will include the below measures when planning the 2017 community mental health survey development, due to start from May 2016 onwards:

- Review the questionnaire design to make it more colourful and engaging.
- Test out a shorter (4 page) questionnaire.
- Test the introduction of a pre-approach letter[1].

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[1] The GPPS experiments found that this initially boosted response rates but this effect disappeared after the reminders and did not change the overall response rate

- Consider targeted interventions that may increase response rates from demographic groups identified as being less likely to respond
- We will look again at alternative methods of sending reminders such as by text message.

We will also consider the feasibility of implementing the following, as longer term aims:

- Whether the current timings for the survey could be changed or shortened, to reduce the period of time between the sampling and fieldwork period.
- Changing the sampling methodology from a random sample to a different approach
- Review the sampling criteria to consider if it should include people with cognitive impairments that may reduce their ability to take part in a postal survey, including a pilot testing any revised sampling criteria.

A number of other potential measures were considered though were deemed to be unsuitable for implementation. These were: changes to the survey mode such as online surveys or interviewer methodologies; incentives in the form of financial or competition entries; and changes to the survey materials such as outer envelopes and greater changes to the cover letter text (see Appendix A for more detail).

The Community Mental Health Survey

Surveys of community mental health surveys have run almost annually since 2004[2]. The response rate for the community mental health survey has stabilised over the last three years achieving a response rate of 29%. This is reassuring, however, CQC is committed to taking all necessary action to resist further decline and to investigate possible measures for increasing response from service users.

An online search undertaken for the publication of the 2015 community mental health survey yielded no directly comparable surveys[3] hence it is not possible to compare the survey response rates to identify whether others are able to achieve a greater response.

Factors Influencing Response Rates

Declining response rates are particularly problematic where the response rate to a survey is already low, as it increases concern about bias introduced, should those who respond to the survey somehow differ from those who choose not to ('non response bias'). As the response rates for surveys decline, the likelihood of non-response bias increases. Non-response bias occurs when a considerable proportion of sampled individuals are unwilling to take part in a survey creating a risk that those who chose to respond are different from those who chose not to respond.

The existence itself of non-response bias is difficult to assess, as there is limited information on the characteristics of non-responders and no indications available to us as to how they would have responded, had they answered the questions in the survey. Due to this limitation we have to rely on development work, data analysis of current surveys, pilot work and anecdotal feedback from stakeholders to even begin to get an insight into the true reasons for non-response.

There are a wide variety of factors that may influence response rates. These factors may include issues related to the individuals themselves such as their demographic characteristics, their type and severity of mental health condition, and their length of contact with mental health services. External factors may also have an effect, such as variation across NHS trusts, and whether a trust uses a contractor. It is likely that there is a complex interplay between these different factors which affect an individual's propensity to respond.

To disentangle these effects a more complex analysis would be needed than is provided here, however this section begins to evaluate the known factors that potentially may affect response. It should be noted that many of these are issues for all surveys in the patient survey programme, whereas others may be particular to the mental health survey. Although not all of these explain the decline in response rate over time, they may explain the historically lower response rate for the mental health survey.

The following factors are discussed below:

- Type and severity of mental health condition
- Other service user characteristics
- Length of contact with services
- Trust variation

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[2] The exception is 2009 when a survey of mental health inpatients was run

[3] www.cqc.org.uk/sites/default/files/20151020_mh15_statistical_release.pdf

Type and severity of mental health condition

The ability of service users to respond may vary greatly between the mental health survey and that for other surveys in the NHS Patient Survey Programme. Some mental health service users are likely to have difficulty in responding to a postal survey, either due to capacity issues or because they are cognitively unable to take part (for example, due to an organic issue such as severe dementia). Service users may ask someone to help complete the questionnaire, or someone could complete it entirely on their behalf but this does not entirely mitigate this barrier to completion.

In 2014 we began to collect ‘care cluster codes’ which allow us to explore this issue of service users’ conditions. As defined in the NHS Data Dictionary[4] mental health care clusters are ‘groupings of people who use mental health services based on their characteristics’. There are 21 mental health clusters and these can be divided into three ‘super classes’:

1. Non psychotic: people suffering from anxiety and depressive illnesses. This also includes phobia, obsessive compulsive, personality disorders and eating disorders.
2. Psychotic: people suffering from a form of psychosis, such as schizophrenia and bi-polar disorder.
3. Organic: people suffering from dementia, including Alzheimer’s and other forms of dementia affecting people’s mental health.

Table 1 below shows response rates by individual care cluster, and aggregated up to superclass. The response rates provide are the ‘adjusted response rate’ and this is described in the text below.

When interpreting the following findings, it must be taken into account that one limitation of the data is the large degree of variation shown across trusts in the recording of cluster data information. In 2014, care cluster data was missing from 13% of the sample data from all trusts and the distribution of this missing data varied between trusts from a low of 1% to a high of 34%. In 2015, care cluster data was missing from 11% of the sample data from all trusts, and the distribution of this varied from a low of 0% (no missing data) to a high of 29%. The care cluster data has been looked at and described below, however due to the limitations of data quality and variation across trusts, this can only be taken as an indication at best, rather than a fully conclusive analysis[5].

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[4] www.datadictionary.nhs.uk/data_dictionary/nhs_business_definitions/m/mental_health_care_cluster_de.asp?shownav=1

[5] Please note: cluster code information is not currently included in the CQC Statement of Administrative Sources as it is not currently used for sampling. Trusts are encouraged to improve their recording of the information through the mental health payment system (guided by Monitor). CQC will continue to raise it as an issue through the survey implementation.

Table 1: Community mental health survey response rates by care cluster

Code	Care Cluster	2014 Response (%)	2015 Response (%)
NON PSYCHOTIC		32	32
0	Variance	27	25
1	Common mental health problems (low severity)	31	31
2	Common mental health problems	33	32
3	Non-psychotic (moderate severity)	33	36
4	Non-psychotic (severe)	33	33
5	Non-psychotic (very severe)	29	32
6	Non-psychotic disorders of overvalued Ideas	31	33
7	Enduring non-psychotic disorders (high disability)	32	32
8	Non-psychotic chaotic and challenging disorders	27	28
PSYCHOTIC		28	29
10	First episode in psychosis	22	20
11	Ongoing recurrent psychosis (low symptoms)	33	34
12	Ongoing or recurrent psychosis (high disability)	28	29
13	Ongoing or recurrent psychosis (high symptom and disability)	27	26
14	Psychotic crisis	23	26
15	Severe psychotic depression	33	36
16	Dual diagnosis (substance abuse and mental illness)	21	16
17	Psychosis and affective disorder difficult to engage	21	22
ORGANIC		29	28
18	Cognitive impairment (low need)	34	34
19	Cognitive impairment or dementia (moderate need)	27	26
20	Cognitive impairment or dementia (high need)	24	20
21	Cognitive impairment or dementia (high physical need or engagement	21	18
Missing data		26	25

Service users from the following care cluster groups were most likely to respond to the survey, with a response rate of greater than 30% in either 2014 or 2015 (ordered by 2015 response rate):

Table 2: Highest response rates by care cluster

Code	Care Cluster	2014 Response (%)	2015 Response (%)
15	Severe psychotic depression	33	36
3	Non-psychotic (moderate severity)	33	36
18	Cognitive impairment (low need)	34	34
11	Ongoing recurrent psychosis (low symptoms)	33	34
4	Non-psychotic (severe)	33	33
6	Non-psychotic disorders of overvalued Ideas	31	33
7	Enduring non-psychotic disorders (high disability)	32	32
2	Common mental health problems	33	32
5	Non-psychotic (very severe)	29	32
1	Common mental health problems (low severity)	31	31

Less like to respond to the survey (with a response rate of less than 25% in 2014 or 2015) were service users from the following care cluster groups:

Table 3: Lowest response rates by care cluster

Code	Care Cluster	2014 Response (%)	2015 Response (%)
16	Dual diagnosis (substance abuse and mental illness)	21	16
21	Cognitive impairment or dementia (high physical need or engagement)	21	18
10	First episode in psychosis	22	20
20	Cognitive impairment or dementia (high need)	24	20
17	Psychosis and affective disorder difficult to engage	21	22
0	Variance	27	25
14	Psychotic crisis	23	26

It can be seen that the poorest response rates come from those with a dual diagnosis, those with a cognitive impairment or dementia, and people from the psychotic class with more severe diagnoses. The NHS data dictionary notes that care clusters 16 (dual diagnosis) and 17 (psychosis and affective disorder) which feature in Table 3 are difficult to engage with services, and it may therefore be expected that they will be similarly disengaged in a survey about these services. Also included in Table 3 are the more severe cases of dementia or cognitive impairment and it may be reasonable to assume that these groups lack the cognitive ability to engage with a postal survey, supporting the notion put forward by the stakeholder group in previous survey developments.

The highest average response rate comes from the cognitive impairment (low need) care cluster which has a high proportion of older respondents and therefore may reflect their general propensity to respond, as noted from other surveys within the national programme.

The survey also collects some limited information on non-response with the outcome of being sent a questionnaire being set to one of six possible outcomes:

1. returned usable questionnaire
2. returned undelivered / patient moved house
3. patient died
4. too ill / opted out / returned blank questionnaire
5. patient not eligible
6. questionnaire not returned and reason not known.

Table 4: Outcome of sending questionnaire to the 2015 community health sample (England)

Outcome	Total sample (%)
1. Returned useable questionnaire	28
2. Returned undelivered or moved house	2
3. Service user died	1
4. Too ill, opted out or returned blank questionnaire	5
5. Not eligible to fill in questionnaire	0
6. Questionnaire not returned - reason not known	63
Total	100

Outcomes two and three are removed from the denominator when calculating response rate on the basis that the patient never had opportunity to participate - we call this the ‘adjusted response rate’.

Table 5: Outcome of sending questionnaire by superclass (2015 community mental health)

Outcome	Non psychotic (%)	Psychosis (%)	Organic (%)
1. Returned useable questionnaire	42	34	24
2. Returned undelivered or moved house	42	37	21
3. Service user died	15	14	71
4. Too ill, opted out or returned blank questionnaire	19	26	56
5. Not eligible to fill in questionnaire	18	4	78
6. Questionnaire not returned - reason not known	39	37	24
Total	39	35	26

When looking at the outcome codes in Table 5, broken down by superclass groupings for the 2015 survey (excluding those with missing cluster information), there were fewer people from the organic superclass returning useable questionnaires (24%) than the other two superclass groups. However, those within the organic superclass group accounted for 26% of the total sample overall. Forty two percent of respondents were from the non-psychotic category, whereas this group accounted for 35% of the initial sample, implying a greater representation of that superclass grouping when it comes to responding. Correspondingly, 34% of all respondents were from the psychosis category, which is lower than the 37% figure within the total sample. As noted, this can only be taken as an indication, however it implies that the organic and psychosis groups are least likely to respond to the survey.

There is increased representation of the organic superclass when looking at the figures for outcome code 3 (service user died), whereby 71% of those who were reported to have died during the time lag between the sample period and drawing the sample were from the organic superclass category (compared with 15% in the non-psychotic group and 14% psychosis). This does not impact upon response rate as such, as those classed under outcome 3 are not included in calculating response rates for the surveys. It is however worth noting that only around one percent of the total sample was coded under this outcome, and so represents a very small minority of the sample.

Unfortunately the coding system used for the surveys does not split out those who were too ill from those who opted out or returned a blank questionnaire (outcome 4). Hence we cannot determine how the higher percentage of people under the organic superclass category differs from the other categories (56% compared with 19% for non-psychotic category and 26% for psychosis).

Table 5 shows that the majority of service users deemed not eligible to fill in the questionnaire (outcome 5) were from the organic superclass category (78% compared with 18% in the non-psychotic category and 4% psychosis), despite making up less than a quarter of the total sample. This finding strongly supports the suggestion made by the advisory group and others that the questionnaire and survey approach are not appropriate for many service users under the organic superclass category. However, it is again worth noting that this group (not eligible) represents less than one percent of the total sample.

It remains the case that for most people (63% of the total sample under outcome code 6), we do not know why they choose not to participate and the actual reasons may relate to outcomes 2 through to 5. This figure is lower for those in the organic category, reflective of the finding that the group accounts for the majority of service users under some other outcome codes. However, there is no means available to determine the 'true' outcome code for over half of the sample, which greatly limits the conclusions that can be drawn on cluster code information and the likelihood to respond to the survey. In any case, the data suggests there may be certain subgroups within the survey who are much less likely to respond to the survey (as shown in Table 3), namely those with a dual diagnosis (substance abuse and mental illness), high cognitive impairment, and psychosis-related disorders.

Other characteristics of service users

The questionnaire for the survey collects demographic information including age, gender and ethnicity that allows us to look which subgroups are more likely to respond (or not) to the survey.

Research, including work carried out as part of the NHS Patient Survey Programme, has shown that certain groups are consistently less likely to respond, and these are: young people, males, black and minority ethnic groups (BME), people from London, people from deprived areas, and people with a mental health condition[6].

Table 6 below shows that this response bias exists in the mental health survey. It can be seen that: females are more likely to respond than males; respondents aged 61 to 65 years are more likely to respond compared with younger age groups; and respondents from the white ethnic groups are more likely to respond compared with those from the other ethnic groups. In interpreting these tables it should be borne in mind that there are of course inter-relationships between these groups.

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[6] www.nhssurveys.org/Filestore/documents/Increasing_response_rates_literature_review.pdf

Table 6: Percentage of respondents and non-respondents to the community mental health survey by key demographics[7]

Demographic	2014 Responded (%)	2014 Did not respond (%)	2015 Responded (%)	2015 Did not respond (%)
Gender				
Male	29	71	28	72
Female	30	70	30	70
Age				
18-35	20	80	19	81
36-50	28	72	28	72
51-65	36	64	37	63
66+	32	68	32	68
Ethnicity				
White British / Irish / Other	30	70	31	70
Mixed / Multiple	24	76	21	79
Indian / Pakistani / Bangladeshi / Other Asian	25	75	24	76
African / Caribbean / Other	25	75	23	77
Chinese or other	27	73	28	72

Length of Contact with services

Another key difference between populations for the mental health survey and other surveys in the NHS Patient Survey Programme is the length of time people will have been in contact with services. People sampled for the community mental health survey are more likely to be in long term contact with services, when compared with other surveys, such as the acute surveys under the programme. For example, the adult inpatient and maternity surveys sample people who are more likely to have had brief or one-off episodes of care. Many respondents to the acute surveys *may* also have their condition or injury cured or healed and subsequently then be discharged from services. Specialist trusts in the acute inpatient survey tend to achieve higher response rates, and it could be that such patients are more engaged and thankful as their condition was resolved and they were discharged.

The results from the survey question asking about length of contact with services are presented in Table 7 below. In 2015, 83% of respondents had been in contact with services for over a year and over two fifths of respondents said that they had been in contact with mental health services for more than six years.

Table 7: Percentage of respondents to the community mental health survey shown by length of contact with mental health services

	2014 (%)	2015 (%)
Less than 1 year	18	17
1 to 5 years	41	40
6 to 10 years	12	13
More than 10 years	29	30

A more static population with more long term contact increases the possibility that some people, particularly at smaller trusts, may be selected for inclusion every year. Unfortunately this cannot currently be tested out further as length of contact is not recorded within the

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[7] Table based on information from trust sample only and will therefore differ from published data. We cannot use respondent provided information to calculate response rates, as we do not have this for non-responders

sample files drawn from NHS trusts for the survey. Although it could be examined by asking trusts to match up sampled individuals across survey years, this could not be done retrospectively as for data protection reasons trusts are asked to destroy their samples on completion of each survey. There would therefore be ethical and confidentiality implications if this were carried out by asking trusts to examine for themselves whether individuals had responded each time, as service users are assured that trust staff will not be made aware of whether or not they choose to respond. Likewise, if such analysis was carried out by the survey co-ordination centre, this would have to be presented to the Health Research Authority with a strong case for the value in doing so, as it would require the co-ordination centre to receive personal information of sample members from trusts (which is not currently received).

It is not therefore possible to determine whether those in continued contact with surveys are showing signs of survey fatigue, though it remains a possible factor in low response. We will be looking at service user figures by NHS trust to determine how likely this scenario is, by examining the overall service user population, and identifying whether trusts collect appropriate information that could be included in the survey samples. This would allow for an ongoing review of the issue to gauge the extent to which re-surveying the same people over time impacts on response rates.

Trust variation

Response rates across all surveys in the NHS Patient Survey Programme vary by trust. In the 2014 community mental health survey this ranged from a low of 23.59% to a high of 36.08%, and in 2015 from a low of 21.32% to 41.68%. The reasons for this variation across trusts cannot be easily pinpointed, but aside from the more minor effect of random variation, possible factors to explain this degree of variation include the demographic profile which they serve, and geographical issues (such as urban or rural). The trust level reporting standardises the data for age and gender[8] of the respondent population. However, there is no weighting to the eligible population applied to the data due to the purpose of the data collection, as described in the 2015 community mental health Quality and Methodology report (see page 17).

A further likely reason for variation in response rates across trusts is the effort and capacity that they have available to put towards running their surveys, particularly in terms of publicising the survey to potential sample members, and encouraging them to respond.

In terms of action that can be taken, the only reason listed above that can be remedied is the effort put in by trusts to publicise the survey. To date, due to the devolved model of the survey programme this has been encouraged by CQC though not enforced. More details on proposed action is described below.

Evaluation of factors relating to response rates

This initial analysis identifies that the postal survey mode is more effective for some subgroups than others. It appears least effective in achieving a response from service users assigned the care cluster codes relating to: dual diagnosis, cognitive impairment or dementia, and psychotic with more severe diagnosis. Likewise service users are less likely to respond if they are male, aged 60 years or younger, and from mixed, Asian, or African / Caribbean ethnic groups.

It is apparent that any measures to improve response rates must encourage response from those groups in particular, to achieve a more representative set of respondents.

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[8] For more information on the methodology, please see the technical document available at: www.nhssurveys.org/Filestore/documents/MH14%20technical%20document%20v2.pdf

The 2016 community mental health survey

The following measures are new to the 2016 community mental health survey, and have been implemented to potentially increase the response rate for the survey. Long term approaches are listed further on in this paper – however these are actions that can be taken within the timescales and budget available at the present time, to help bolster and supplement the general focus on improving response.

Encouraging trusts to publicise the survey

As identified under the ‘Trust variation’ section above, it is expected that there is variation in how NHS trusts publicise and engage service users in the community mental health survey. To date this has not been enforced nor monitored in any sense, due to the devolved nature of the survey programme. However, it is apparent that CQC could do more to prompt all trusts to pay greater attention to survey publicity.

The community mental health survey does not have the benefit of relating to standard locations at which survey publicity materials such as posters could be placed – such as hospital wards, as done for the inpatients survey. However, it has the alternate benefit in that many service users have ongoing contact with services. Hence targeted publicity could be made via trusts to reach the service users who are most likely to be sampled. Unfortunately the sample period has now passed for the 2016 survey (September to November 2015), however there may be opportunities nonetheless to reach service users via trusts.

Firstly, the guidance and materials that are made available to trusts have been reviewed by the CQC team, to improve the quality and ease of use, and to brainstorm any additional means for reaching service users (for previous surveys the guidance consisted of a template press release). A bulletin was sent to trusts late January 2016 outlining suggestions for promoting the survey. The trust briefing held in mid-January also referred to communications work.

Secondly, we will make full use of the CQC regional communications teams and their established relationships with communications departments at relevant trusts, to further encourage them to publicise the survey to service users both before and during fieldwork. The CQC regional communications team signed up to work with the CQC surveys team on this, and the planning with be carried out by both teams during December and January, with the aim to contact trust communications departments from January. The publicity and messaging will then run prior to and during fieldwork (from January onwards).

Social media messaging

An additional new approach for the 2016 survey will be to utilise social media to encourage service users to respond, as well as engaging with user groups and other bodies to request that they send similar messages out, as an endorsement of the survey and to encourage them to respond. By selecting appropriate user groups, and through the use of this medium directly from CQC, we aim to get a positive message out to hard to reach groups and younger people (for example via Young Minds).

The CQC public engagement team have agreed to run a social media piece of work for the 2016 survey, along with other tactics, to increase engagement and response. This will be planned throughout December and January, with a view to run all messaging throughout fieldwork.

Cover letters in mailing packs

In reviewing the potential measures for increasing response rates, it became apparent that improving the text in the covering letters would be a quick and relatively cost free way of incentivising people to take part. Good practice recommendations note that the covering letter must be should be short, simple and clearly set out what the survey is about and the benefits of taking part in the survey.

Space is extremely limited within the cover letters due to the amount of text we are required to include regarding information governance and data protection issues. This had caused the length of the letters to increase over time. However, the layout and design of the covering letters has not changed much since the start of the survey programme and so we reviewed the design of the covering letters, to make them more engaging.

The following changes have been made to the cover letters for the community mental health survey:

- The text has been re-arranged so that people first read about the purposes of the survey before the more official text on information governance and confidentiality issues.
- The amount of information within the cover letter has been reduced overall to make it shorter.
- The language has been changed to appear friendlier and less official.
- The title has been changed from ‘Service User Questionnaire’ to ‘Please tell us about your experience with NHS mental health services’.

Planned developments for the 2017 survey

The following tasks have been identified as likely measures for increasing response rates. Due to timescales and budget limitations they could not be implemented in time for the 2016 survey. However, development work for the 2017 community mental health survey will begin from May 2016, and the following actions will be scheduled to begin from then on. A list of other measures that were considered, but deemed not suitable for implementation, are listed in Appendix A.

Questionnaire redesign

The NHS patient survey programme uses a black and white questionnaire as this is most economical for trusts when printing. However, the children’s inpatient and day-case survey in 2014[9] used a more colourful questionnaire[10].

The 2015 acute inpatient survey included a pilot looking at the impact of using a more colourful questionnaire which it is hoped will be more engaging and encourage people to respond. Fieldwork for the 2015 acute inpatient survey completes in January 2016, results will be available to CQC around February 2016, and published in Spring 2016.

We expect that the findings of the inpatients pilot can be generalised to the community mental health survey. However, this will be subject to a careful review to ensure that implementing changes does not risk reducing the response rate further. The findings of the Inpatient re-design (as part of the 2015 piloting work) will be reviewed when available in February 2016 to inform the final decision for the community mental health survey. It is expected that a re-design will either improve response rate or show no change, however if a reduction is shown for the 2015 inpatient pilots then a more cautious approach will be taken

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[9] www.cqc.org.uk/content/children-and-young-peoples-survey-2014

[10] www.nhssurveys.org/surveys/778

to community mental health. Depending on cost implications, the community mental health development work may therefore include a re-design followed by a full roll-out rather than a pilot. At a minimum, we expect to at least pilot a redesigned questionnaire, if the inpatient pilot findings are positive.

A disadvantage of including colour in the questionnaire is increased costs to trusts. This is also being evaluated as part of the inpatient pilot work and will need to be considered for the mental health survey. The use of limited colours is likely to keep costs down.

Reduce the length of the questionnaire

The questionnaire for the community mental health survey is currently eight pages, compared with twelve pages for the acute surveys. Many stakeholders consulted during the redevelopment of the survey in 2014 felt that an eight page questionnaire was too long[11].

For practical reasons it is desirable that survey questionnaire length is in multiples of four (i.e. four, eight or twelve pages). This is due to the practicality of printing the questionnaire as it allows it to be printed in a booklet style. This reduces the possibility of pages being either accidentally torn off or missed out which may occur when a questionnaire is stapled in one corner.

Reducing the questionnaire length to four pages will be extremely challenging given many questions are used in various indicators and assessments including their inclusion as Tier One indicators in CQC’s Intelligent Monitoring system, and in NHS England’s National Patient Experience Outcome Measures.

Research into the impact of questionnaire length on response rates has yielded mixed results. While there is some evidence to suggest that questionnaire length does not have an impact on response rates[12], this has not been trialled for the mental health survey.

An alternative option is to provide a shorter version to specific groups (such as minority ethnic groups) who we know tend not to reply.

Budget allowing, we expect to include pilot work involving a shorter questionnaire for the 2017 survey. It is expected that this may take the form of a pilot testing the impact of a reduced length questionnaire for those groups known to be less likely to respond. This would require a prioritisation exercise to be undertaken with key users of the survey data and statistics. To roll it out fully in the first instance would not only risk losing trend data without knowing the full benefit, but would also require extensive consultation with users of the data (such as NHS England, Department of Health, and others). For this reason, it will be considered as a pilot option only, and we will consult with stakeholders at the planning stage of this to gauge whether there is agreement on this – to gauge views on whether the loss of trend data and survey items is a worthy sacrifice.

Pre-approach letters

There is evidence that pre-approach letters sent to potential respondents prior to a survey, telling them about the forthcoming survey, can increase response rates.[13]

Experiments conducted as part of the GPPS survey programme to look at increasing response rates found that the inclusion of a pre-survey letter initially boosted response rates

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[11] www.nhssurveys.org/surveys/750

[12] http://jpubhealth.oxfordjournals.org/content/25/3/197.full.pdf

[13] Dillman, D. (2000), Mail and Internet Surveys: the Tailored Design Method, New York: Wiley

but this effect disappeared after the reminder mailings and did not change the overall response rate[14].

As with the questionnaire redesign, we will review the findings of the inpatient survey pilot in February. If that testing yields an increase in response rate, we will consider rolling it out for the community mental health survey, although this would take the form of a pilot if either: the inpatient pilot results showed little or no effect on response, or if there are any concerns around its effectiveness due to the different sample population.

Target under-represented groups

As noted elsewhere in this paper increasing the overall response rate will not necessarily increase response rates in any under-represented groups, as this may simply encourage those with a higher proclivity to respond, to respond in greater numbers.

A further option is to consider targeted interventions that may increase response rates from groups (such as minority ethnic groups and younger people) less likely to respond. For example, a shorter version of the questionnaire could be sent out to some groups, or SMS reminders sent to younger people.

A disadvantage of this approach is that it introduces different methodologies into a programme that we have generally strived to keep consistent. It also makes the survey more complex to administer, which increases the risk of error, which may be an issue for trusts who do not use an approved contractor.

However, prior to the survey development phase for the 2017 survey, a review will be conducted to examine further the options and potential methods for targeted interventions that may increase response rates from groups less likely to respond. We propose this to be undertaken from Spring 2016, in the form of a literature review and evidence scan. This work would inform the potential for piloting or changes required to methods, and allow sufficient time then for planning for pilot work and seeking the necessary governance approvals in advance of the survey.

Use of SMS text messaging

With mobile phone ownership now commonplace, mobile phones present another option for reaching people. The use of tablet devices and phones has increased making access to the internet easy and instant.

Existing research suggests that sending reminders by another mode can help increase response rates[15]. This was piloted as part of the 2007 acute inpatient survey[16]. Results were negative and found that those who received an SMS text reminder were significantly less likely to return a questionnaire, with a large difference in the proportions responding across the two groups. However, it should be noted that a postal strike caused major disruption to the fieldwork period for the 2007 pilot survey resulting in a much abridged fieldwork period which ran for seven weeks instead of fourteen. This may have affected the outcome of the pilot, and hindered any effect that the SMS text may have otherwise had.

A practical limitation of this approach at that time was that trusts only had mobile phone numbers on their records for 12.5% of people in the sample (ranging from 6.3% to 27.0% across trusts).

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[14] Report unpublished.

[15] www.nhssurveys.org/Filestore/documents/Mixed_mode_report.pdf

[16] www.nhssurveys.org/Filestore/documents/The_development_report_for_the_2007_Inpatients_survey_v1.pdf

As this work is now several years old, and with mobile phone use increasing and technology always evolving, it may be worth investigating whether trusts' record keeping has improved, and whether this information is now held more routinely by mental health trusts.

The increase in ownership of smartphones also presents the possibility of using more innovative approaches. For example, we could send cover letters, and / or reminders with a 'QRS symbol' which can be scanned by a smart phone or device and linked to a website. Service users with smartphones could then scan this and be taken to the survey link and quickly complete online. This would only work for those people with smartphones / devices and as we cannot know this, we would also need to send a web address and / or postal questionnaire as well for those people without smart devices.

The first stage is to ascertain whether mobile phone numbers are routinely recorded at trusts. Exploratory work will be conducted by the Co-ordination Centre in spring 2016, to inform the planning for a pilot of this method for contacting service users. This will include a review to determine whether there are now more mobile numbers across the sample as a whole, and for certain subgroups (namely age, ethnic group, and cluster code groupings). Consultation with trusts would be required to determine: a) what information is held on records regarding availability of mobiles etc and b) usage of smart phones. It seems unlikely that trusts will have this information stored or recorded universally for the latter, and so other data will also be sought out as part of the Co-ordination Centre's review, to attempt to estimate the use of smartphones across particular groups of service users.

Future focus of development work and response rate review

The following are additional areas that can be investigated to determine the feasibility of improving response rates for the community mental health survey. The likelihood of planning for and implementing these are less certain than those listed above, due to the requirement to consult on major changes to the surveys. The measures below will be looked into further during the first half of 2016, through two routes. These elements will be addressed through the wider response rate work that is proposed for consultation in early 2016 (see 'Consultation on the NHS Patient Survey Programme'). However, as responses from the consultation will not be received until mid-2016, supporting work will be undertaken prior to the consultation outcome to ensure that the issue is addressed as far as possible for the community mental health survey, with a particular focus on the issues unique to the population. Any implementation following that would be dependent on timings, and hence they may be relevant to the 2018 survey, rather than the 2017 survey.

Reduce the time lag between sample and fieldwork period

Development work[17] for the survey has found a clear relationship between how recent the service user's date of last contact is and their likelihood to respond to the questionnaire, with people more likely to respond to the questionnaire if they have recently been seen by services.

The time lag between the sampling period for the survey (September to November) and the survey fieldwork (February through to June) is longer compared with other surveys in the national patient survey programme. The main reason for this difference is due to the current timings, as the preparation time for the survey includes the Christmas period.

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[17] Report available at: www.nhssurveys.org/Filestore/documents/Extension_of_fieldwork_for_inpatient_survey_2007.pdf

Fieldwork for the survey used to commence in January though was pushed back to February due to feedback from trusts that the reduction in staffing over this period, combined with the need to draw a sample, caused an increased burden. This time-lag is perhaps mitigated by the fact that the majority of people (80%) sampled for the survey have been seen by the trust in the time period following the sample period, and the questionnaire asks them to consider the last time they saw someone form mental health services. However, this does leave around a fifth of people who are potentially being asked to recall an experience that may have been five months before receiving a questionnaire (if their last contact was in September and they receive a questionnaire in February) or indeed much longer if responding to a reminder mailing.

We will consider whether this gap can be reduced, however, this would likely mean moving the timing of the survey so that the preparation time does not straddle Christmas. The time period for the survey is constrained by a number of factors including the number of other surveys which we need to fit into the programme each year (in terms of the burden on contractors, Co-ordination Centre, and CQC), and we would need to balance any perceived gain against the difficulties of moving the timing of a well-established annual survey. Any large change to the fieldwork timings for the survey would also necessitate the sampling period being changed. A simple solution may perhaps be to sample October to December (rather than September to November), however, sampling from December is not desirable as it is an atypical month with more staff on leave than is usual, and perhaps reduced appointment availability.

A further option is to reduce the sampling period to two months, such as October and November, which would increase the recency of the experience.

With the survey programme currently being reviewed, we will consider whether this would enable the timings of the survey to be changed and / or the sampling period shortened to avoid straddling the Christmas holiday period.

Change the sampling methodology for the survey

It is prudent to evaluate whether we are still using the correct methodology, in particularly the sample methodology (see Appendix A for details on changing the survey methodology itself).

Any substantive changes to the sampling methodology will interrupt trend data. As well as impacting on CQC use of the data, this would also affect all other organisations that use the data such as trusts, NHS England and the Department of Health. We would therefore need to consult externally on any proposed changes. As the survey has undergone two substantial redevelopments fairly recently (in 2010 and 2014) there is already a lack of long term trend data for this survey. It is unlikely that further interrupting the trend data again will be welcomed by stakeholders.

The samples for the survey are drawn by trusts themselves, and uses a random sampling methodology. An equal probability random sample has several advantages:

- It is reasonably straightforward for trusts to draw a sample. We want to keep the sampling instructions as simple as possible to minimise the possibility of error
- Everyone who meets the eligibility criteria has an equal chance of being selected
- If drawn correctly it should approximate the actual trust population in terms of demographics such as age, gender and ethnicity.
- The use of a non-probability sample may make data unsuitable for inclusion in indicators by CQC, and other organisations who use the data. Many of the statistics used in the analyses (such as significance tests and the ‘expected range’ statistics we use to

analyse trust scored results) are based on the principles of using a random sample. This analysis allows results to be used for performance assessment.

Changing the methodology may allow us to potentially make more use of the data if, for example, we wanted to disaggregate it in different ways and to different levels. However, we suspect that even if the sampling methodology is changed, we may not see a corresponding effect on response rate.

We will evaluate alternative sampling methodologies to determine if any could be implemented to help promote response rates, either as a whole, or from those groups who we know are less likely to respond. Possible alternate sampling strategies are listed below (two additional approaches are described in Appendix A, as these are not suitable for further evaluation):

Booster samples

A booster sample increases the representation of certain subgroups that would not normally be adequately represented in a main survey, without the expense of increasing the sample size for main survey as a whole. It is not uncommon for surveys to boost samples for particular ethnic groups for example.

We may wish to consider including a booster sample for particular groups we know have poorer response rates, such as those listed previously as less likely to respond (Table 3).

However, it should be noted that simply increasing sample size is not a solution to increasing response rates, and does not address the underlying causes of this. A further disadvantage is that it increases complexity of drawing the sample for trusts and therefore the risk of error. We may also need to adjust the weighting methodology which would likely interrupt the trend data. This may be difficult because as discussed elsewhere in this paper, trust recording of ethnic groups can be poor and we may therefore be forced to exclude people without an ethnic coding which risks introducing bias into the survey.

Stratified samples

A stratified random sample is a random sample in which members of the population are first divided into strata, then are randomly selected to be a part of the sample. This can help to ensure representative coverage of different strata of the population being surveyed such as age groups or ethnic groups for example.

While this approach would not necessarily increase response rates, depending on the strata selected, it would mean we are able to analyse the data at a lower level than we are currently able to, which would bring additional benefit to all users of the statistics. The feasibility of this would have to be explored further, as the additional complexity within the sampling could lead to an increase in errors made by trusts in drawing the sample. Measures to reduce this risk would be to either design an automated system for the stratification, or to apply for ‘section 251 support’ for the Co-ordination Centre to accept all patient information to then draw a sample for each trust.

Review the sample eligibility for the survey

As previously discussed, stakeholders have raised concerns during survey development work regarding the breadth of the sample for the survey, and cognitive testing has reinforced that a questionnaire does not work with some people. Taking action along these lines will not improve response rates as such, instead it would be a reduction in the scope of the survey to include a narrower group of service users.

As seen in Table 3 those less likely to respond include those with a dual diagnosis, those with a cognitive impairment, and people from the psychotic class with more severe diagnoses. If some people are simply unable to respond to a postal survey, and / or this is unsuitable for them, this means that a considerably large proportion of the sample for the survey will include people who are highly unlikely to respond, for reasons beyond the standard issues that apply to survey response. Table 5 showed that around 10% of people in the organic superclass will opt out due to being ‘too ill’ and this was highest for the ‘cognitive impairment or dementia (high physical need or engagement)’ cluster where 16.5% opted out in 2015.

Reducing the eligibility criteria for the sample is dependent on the quality of the information collected about eligible groups, and so any strategy aimed at sampling people from certain cluster code groupings would only be feasible if sufficient information is collected routinely across all trusts. This isn’t an option at present but may become feasible if cluster code recording improves over time. It would however have two major disadvantages:

- We would be removing the opportunity for particular groups to feed back on their experiences. If they are having particularly poor experiences of services, and we remove them from the survey, these experiences risk being hidden.
- Changing the sampling criteria will disrupt the trend data for the survey. As the survey has had two substantial redevelopments fairly recently (in 2010 and 2014) there is already a lack of long term trend data for this survey. It is unlikely that further interrupting the trend data again will be welcomed by stakeholders without good reason for it.

Nevertheless, the benefits would be to prevent a cause of distress for service users or relatives of those for whom the survey isn’t suitable, and the survey as a whole would be more relevant to the target population that are being surveyed.

Ongoing review of response to the survey

We will continuously review response rates for future community mental health surveys, and this will include assessing the impact of all new measures introduced, their impact on subgroups of the population, and ongoing evaluation of cluster code response rates. As the measures introduced to improve response rates begin to take effect, we can determine whether any additional measures are needed to further increase response.

Likewise, if cluster code data recording at trusts improves, we will be in a better position both to conclude whether or not a postal methodology is suitable for all groups, and to take action accordingly. If the scope of the survey were to be reduced to certain groups in the future it would be essential to introduce other feedback mechanisms to ensure that CQC gains a complete picture of service user experience. There are existing feedback mechanisms used within hospice care and other adult social care settings which could be used as a starting point to design other methods of capturing feedback. Although these do not provide quantitative data in the same way as the survey programme, these methods allow for feedback to be utilised during CQC inspections. An alternative would be to apply a similar postal method to collect the views of carers or family/friends of service users. All feasible options would be reviewed as necessary to develop the data collection accordingly.

Appendix A

Actions considered but not taken further

Additional text in covering letters

For the 2014 A&E survey, and the 2014 Inpatient survey, the covering letter that respondents receive with the first mailing and the second remainder was modified to allow space for trusts to include a paragraph stating how they used results from the last survey. It was hoped that this might encourage people to respond by demonstrating how their feedback is actioned.

This was only taken up by a minority of trusts and was discontinued as approved contractors feedback suggested that some trusts were not using this space appropriately and used it to ‘market’ themselves. It was also felt to undermine the methodology of the survey programme, as an important principle is that all trusts must carry out the same survey in the same way to enable fair comparison of results.

Online response

Offering an option for on-line completion would be more in keeping with the current digital age, where fewer items are being posted generally and people are conducting much of their lives on-line. With the availability of online mental health support increasing in recent years, both via the NHS[18] and in the form of peer support websites, it seems likely that many people sampled for the survey may have received some treatment online or routinely access the internet. The use of tablet devices and phones making internet access easy and instant has also increased in recent years. On the surface this has potentially large financial benefits in terms of saving money on printing, postage and data entry.

However, despite this on-line completion tends to be low across the general population. An on-line completion option is offered by The GP Patient Survey (GPPS). In the latest report (at the time of writing) published July 2015[19] [20], the response rate was 32.5%, with 858,381 respondents of whom 34,613 (around 4%) completed the survey on-line. The acute survey of children’s experiences of inpatient and day case published by CQC in July 2015 also had a very low uptake of the on-line response option, with less than 1% of respondents choosing to complete the questionnaire online.[21]

Results on research into the effectiveness of on-line completion are mixed, though some research suggests that significantly lower response rates are actually achieved when a concurrent online response is added to a postal survey as an option[22]. Options for on-line completion have been piloted on two occasions alongside the inpatient survey (2008 and 2013) and alongside the A&E survey in 2012. Uptake of this option was low and found no improvement in response rates:

- In 2008, pilot work carried out alongside the inpatient survey [23] examined whether providing on-line completion in English, alongside a number of other commonly spoken

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[18] http://www.nhs.uk/conditions/online-mental-health-services/pages/introduction.aspx

[19] http://gp-survey-production.s3.amazonaws.com/archive/2015/July/14-008280-01_Technical%20Annex%202014-2015.pdf

[20] http://gp-survey-production.s3.amazonaws.com/archive/2015/July/July%202015%20National%20Summary%20Report.pdf

[21] http://www.cqc.org.uk/content/children-and-young-peoples-survey-2014

[22] http://poq.oxfordjournals.org/content/early/2012/10/20/poq.nfs047

[23] www.nhssurveys.org/Filestore//documents/Increasing_response_rates_to_the_NHS_Patient_Survey_Programme_-_Inpatient_Online_Pilot_2008_Report.pdf

languages, can improve response rates. Results did not show any significant increase in response rates (neither in general nor amongst BME groups) as a result of offering an online completion option in English and in other languages.

- Pilot work carried out carried out alongside the 2013 inpatient survey found offering option of on-line completion had **lower** response rates compared with the group offered only postal completion. It should be noted that the online option was piloted in conjunction with a pre-approach letter so it may not be possible to disentangle the effects[24].
- The 2012 pilot carried out alongside the A&E survey found that when patients received a paper questionnaire at the same time as an invitation to complete the survey online, the vast majority will opt to answer the paper questionnaire[25]

In terms of the community mental health survey, guidance from the Mental Health Foundation on providing online information to people with mental health needs implies that some people may be deterred from completing an online survey if they felt their identity would be recorded[26]. Although stringent measures are taken across the survey programme to maintain the confidentiality of respondents, we rely on people to trust the reassurances that are given, and to provide some personal information when responding (such as age, gender, etc). The guidance also states that access is not available to all, particularly those from low income households or with 'additional disabilities'.

A practical difficulty and the main barrier to moving to a truly on-line approach is that NHS trusts do not routinely collect and update email addresses. This means that contact has to be made through other means, in this case postal communication, with an option to take part on-line by typing in an address into a browser meaning the approach is therefore not fully 'on-line.' This approach may actually increase the burden on respondents as they have to make the decision as to how to respond, and if on-line, they must actively type the address into a browser .The pilot work described above have essentially tested the feasibility of allowing an alternative mode of response, rather than tested the provision of an alternative mode of contact. If trust record keeping improves in the future, we may be able to offer a more fully on-line approach.

It is important to note that while on-line completion offers another means of taking part, it does not necessarily address the underlying reasons why people choose not to take part. It is also unclear if people responding on-line would have responded anyway using the paper methodology.

Survey materials: outer envelopes

In order for someone to take part in the survey, they have to first make the decision to open the envelope in which it arrives. This means that the design and appearance may have an effect. Variations can include: personalisation, size of envelope used, colour, form of postage (stamped or franked, stamped may appear more personal) and use of logos or other identifiers. Studies examining this have yielded varying results[27] [28].

Cognitive testing for the GPPS survey suggested that some interviews said they would pay more attention to mailing received if it included the NHS logo on the outer envelope.

There are difficulties in implementing this for the NHS Patient Survey Programme as the instruction manual requires the use of plain envelopes to ensure confidentiality is

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[24] Unpublished report
[25] Unpublished report
[26] http://www.mentalhealth.org.uk/help-information/mental-health-a-z/I/internet/
[27] www.jasnh.com/pdf/Vol7-No1-article2.pdf
[28] http://link.springer.com/article/10.1007%2FBF03337749

maintained, and the survey is not recognisable as being about health care, in case people have not shared this with those with whom they live. It is highly unlikely that such a proposal would receive section 251 support, based on previous requests from the approval committee.

Accessibility

It is possible that some people may be unable to respond to a postal survey. In addition to mental health issues, there are many possible reasons for this including disability or poor English and / or literacy.

Research carried out as part of the development work for the national patient survey programme suggests that poor literacy in English is a reason for non-response in some BME groups.[29]

There are some limited measures in place to address these issues:

- Questionnaires may be completed with the assistance of a friend, family member, carer or health care staff.
- A telephone translation service is offered offering translation in the 20 most commonly spoken languages in England
- For those with leaning difficulties, MENCAP telephone offer telephone assistance with completing the questionnaire.

To completely overcome issues of poor literacy one option would be to move to an interview methodology which would render the survey programme cost prohibitive. Alternatively, greater accessibility options are offered by the GPPS survey which currently offers online, braille and large font, sign language and telephone completion. The on-line completion option includes an option to complete the questionnaire in 13 different languages. Of the 34,613 completed on-line, 832 (around 2%) were completed in a language other than English and 19 using sign language. Polish was the most common language other than English to be completed on-line.

Offering on-line completion in a language other than English was piloted alongside the 2008 acute inpatient survey[30]. The pilot did not show any significant increase in response rates (either in general or amongst BME groups) as a result of offering an online completion option in English and in other languages. Uptake of the online option was low in all languages (1% of sample), especially so for non-English completion (0.2% of the sample). The report noted that cost per response was unacceptably high.

Whilst broadening the accessibility options of surveys in the NHS Patient Survey Programme is an option, the cost to trusts or CQC (if provided centrally by the co-ordination centre) of providing these need to be balanced out against any potential benefit. It is also not known if respondents using these options may have responded anyway by other means such as use of the telephone service or with the help of a friend or relative.

In summary it should also be noted that offering translated questionnaires is also not recommended for a variety of reasons including:

- The meaning of questions can change when translated

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[29] See for example: www.nhssurveys.org/Filestore/documents/Increasing_response_rates_literature_review.pdf

[30] www.nhssurveys.org/Filestore//documents/Increasing_response_rates_to_the_NHS_Patient_Survey_Programme_-_Inpatient_Online_Pilot_2008_Report.pdf

- We do not know what language people speak so have to approach them in English
- The large cost of translating questionnaires

Changing the Sampling Methodology

As mentioned previously, the following two changes to the survey methodology have been deemed unsuitable for the community mental health survey, for the reasons outlined below.

Panel Survey

Panel surveys include people who have agreed to take part in multiple surveys over time and are typically used to track changes in attitudes, opinions or behaviours over time.

The main advantage of this approach is that higher survey response rates can be expected as panel members have already agreed to participate in research.

However, panel surveys have a number of disadvantages. The panel is expensive to set-up and maintain and would therefore be an increased burden on either the trust or the survey co-ordination centre if centrally administered. Sample attrition is an issue as people lose interest, leave the panel and need to be replaced. If people leave mental health services they would need to be replaced to ensure the panel does not just include those in long term contact with services.

Whilst quotas may be used to ensure coverage of different ethnic groups and demographics, it seems likely that the panel risks the same sorts of bias, in that people who are unlikely to respond to a survey are presumably just as unlikely to join a panel. The panel would be self-selected and made up of volunteers and is therefore a non-probability sample. This may also mean that data is not suitable for performance assessment uses by CQC or others.

With the present random sample approach, all eligible service users have an equal chance of selection. A panel survey means that if they do not chose to be part of the original panel, they are then excluded from future surveys which people may feel is unfair.

Perhaps the most serious disadvantage for a survey with the purpose of measuring patient experience, panel members are likely to become more informed over time which may result in their views becoming atypical (known as ‘conditioning’). This means that a survey may not be measuring changes in trusts but changes in the panel members. Indeed, this is the typical purpose in panel surveys to measure attitudinal changes.

As we want to understand peoples’ experiences, a panel sample may not be appropriate for the community mental health survey, and we may be better to use a random based sample rather than a predetermined set of people.

‘Bought’ samples

Samples may also be ‘bought’. Typically these are bought on-line meaning they have email addresses which would also enable a fully on-line option to be offered.

Even if samples could be bought that identify users of community mental health services (and we expect not), this approach has several disadvantages. The current purpose of the NHS Patient Survey Programme is to provide data at trust level which trusts can use for service improvement, and which CQC and others may use for performance assessment. It is extremely unlikely this would be possible using this approach. The sample is also extremely unlikely to be representative as it will include people who are actively engaged in surveys. It also excludes anyone not included on these lists from participation.

Changing the Survey Methodology

An alternative to a postal methodology is an interviewer methodology, whether that be face to face or by telephone. This could be carried out by trained interviewers or even by service users themselves who have been trained to undertake this work. This methodology would also enable us to collect more detailed information on reasons for non-response, as interviewers code reasons such as non-contact and refusal using an extensive coding frame. Interviewer administered surveys also have the benefit that self-completion elements can be provided in the form of CASI (Computer Assisted Self Interviewing): normally a series of questions that cover sensitive or risk taking behaviour (sexual behaviour, alcohol and banned substance consumption, gambling etc) which respondents complete themselves and don't give verbal answers to an interviewer.

While interviews have the advantage of collecting more in depth information, the major disadvantage is the cost of carrying out an interviewer survey is much greater compared with a postal survey and would almost certainly render the community mental health survey cost prohibitive. It would also be extremely time consuming to carry out the number of interviews required to enable data to be used for performance assessment purposes.

We must also consider the purposes of surveys in the national patient survey programme which is to provide comparable feedback on the experiences of people using healthcare services over a range of areas. Data from the surveys is not intended to be a trusts only source of data on patient experience; trusts are encouraged to use these results to identify areas where they are not performing as well and investigate this further using different methodologies that allow a more in-depth understanding such as interviews or focus groups to gain greater insight into these issues.

Changing the methodology would also not necessarily address the reasons for non-response, as people would still need to be recruited to participate in interviews. Historically, the response rate for face-to-face surveys have been higher than other modes of data collection, which provided a benefit to counteract the more complex sampling design, closer fieldwork management and greater expense of that mode. However, the average response rate for the inpatient survey is currently around 47%, which is higher than the response rate for Understanding Society (the largest household panel study in the UK at the moment) which normally achieves around 40% per wave maximum, as a fully face-to-face survey. As noted elsewhere in this paper, changes appear to be occurring in terms of the effectiveness of mode, as the response rates for some interview surveys (such as the Labour Force Survey[31]) are also declining, which could be taken to imply that mode is not necessarily a reason for non-response.

Incentives

This intervention can be offered in two ways: a benefit (such as monetary, or entry into a competition etc.) to encourage people to respond, or by providing people with a reason to respond. The latter is addressed through the inclusion of the CQC flyer, revised cover letter, and the other publicity and communications work that is planned.

The inclusion of incentives in the form of benefits can be rejected for many reasons: trusts may be criticised for offering an incentive, either monetary or otherwise, for people to take part in a survey due to it being taken from public funds. It also has methodological difficulties as a principle of the survey is that all trusts carry out the same survey in the same way, yet this may be dependent on available budgets across trusts.

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[31] http://webarchive.nationalarchives.gov.uk/20140721132900/http://www.statistics.gov.uk/elmr/12_08/downloads/ELMR_Dec08_Bright.pdf