

GUIDANCE MANUAL FOR THE NHS MATERNITY SURVEY 2010

THE CO-ORDINATION CENTRE FOR THE
ACUTE SURVEY PROGRAMME



making patients' views count

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Adherence to the procedures outlined in this document

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

Updates

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

This document is available from the Co-ordination Centre website at:
<http://www.nhssurveys.org/>

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1 Introduction: patient feedback and the NHS Plan

1.1 The Care Quality Commission

The national patient survey programme was established by the Department of Health and has been operating since 2002. The Care Quality Commission (CQC) began operating in April 2009, superseding the regulatory functions of the Healthcare Commission, and is now responsible for administering the programme. CQC is the independent regulator of health and adult social care services in England, and also protects the interests of people whose rights are restricted under the Mental Health Act. Whether services are provided by the NHS, local authorities, private companies or voluntary organisations, CQC makes sure that people get better care.

As set out in *Voices Into Action*¹, the statement on involving people, CQC is committed to involving people who use services in all its work, and ensuring that the providers of care services themselves involve people and respond to their views. The experiences of patients, people who use services, their carers and families are at the heart of the Care Quality Commission's work: it is the aim of the Care Quality Commission and the Coordination Centre to make sure better care is provided for everyone.

By ensuring that organisations carry out these surveys in a consistent and systematic way it is possible to build up a national picture of people's experience and, with care, to compare the performance of different organisations, monitor change over time, and identify variations between different patient groups. The surveys are expected to inform local improvement activity; they are seen as an important source of information for people and for informing commissioners of services. In addition, the survey results are used as a data source by the Department of Health and are made available to the public via the Commission's website.

1.2 The Co-ordination Centre for patient surveys

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

1.3 Why we need patient feedback

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

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

¹ http://www.cqc.org.uk/publications.cfm?fde_id=12419

1.4 Patient feedback and the NHS Plan

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

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

- providing information to support local quality improvement initiatives
- tracking changes in patient experience locally over time
- providing information for active performance management
- providing information to support public and parliamentary accountability
- providing information for the Care Quality Commission's regulatory activities including registration and ongoing monitoring of compliance

1.5 Measuring performance over time

The Care Quality Commission will publish benchmarking data from the survey to allow trusts to make meaningful comparisons between themselves and national benchmarks based on reliable data. Asking each hospital trust to carry out a maternity survey in a consistent way builds a detailed picture of patients' experiences in NHS hospital trusts. Information collected nationally in a consistent way is also essential to support public and parliamentary accountability.

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

1.6 Basic requirements for NHS trust maternity survey

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

- Please contact the Co-ordination Centre, by e-mail, no later than **19th March 2010** to tell us who is carrying out your survey (i.e. whether it will be carried out by an approved contractor or in-house): **maternity.data@pickereurope.ac.uk**
- The survey must be carried out using a postal questionnaire.
- If you are conducting the survey in-house then, before drawing the sample, you must submit a formal declaration to the Co-ordination Centre, as outlined in Section 6.1 - *Statements of compliance with data protection*
- The samples must consist of all women who had a baby during **February 2010** as outlined in Section 10 – *Compiling a list of women* [If your trust has fewer than 250 births in February, please contact the Co-ordination Centre for further advice on including women who had a baby in January 2010.]
- The sampling procedure set out in this guidance must be followed. To do this, you will need to work closely with the person who draws the sample, and check carefully that this guidance has been adhered to. For further details see Section 10 – *Compiling a list of women*.

- Sample data must be submitted to the Co-ordination Centre for final checks before mailing as outlined in Section 11– *Final sampling inspection by the Co-ordination Centre*. We need to receive these sample files between **5th and 30th April 2010**.
- You should aim to obtain the highest response rate possible. For this survey, the target response rate is 60%. Three mailings will be necessary to achieve this target. However, trusts should facilitate higher response rates through maximising their collection period and publicising the survey. See Section 13 – *Publicising the survey*.
- Weekly submissions of details of response rates and helpline calls to the Co-ordination Centre will start from **15th April 2010**. A spreadsheet has been created for this purpose. For further details see Section 12 – *Weekly monitoring*.
- The questionnaire must include the 77 core questions. See Section 14 – *The core questions and question bank*.
- The standard covering letters and reminder letters (which can be found under the Maternity Survey section of the NHSSurveys website) must be used as outlined in Section 15 - *Materials*
- **Two reminders must be sent to non-responders**, even if a 60% response rate is already achieved, as outlined in Section 16.6 – *Sending out reminders*.
- The data must be checked carefully for errors before submitting it to the Co-ordination Centre. Specific advice on how to carry this out is included in Section 17.3 – *Checking for data errors*.
- The data from the questions, and the required information about the patient sample, must be submitted to the Co-ordination Centre in the form outlined in Section 17.4 – *Submitting data to the Co-ordination Centre* by **20th August 2010**.
- Two **paper** copies of the questionnaire and the covering letters used for **each mailing** and the checklist must be submitted to the Co-ordination Centre in the form outlined in Section 17.4– *Submitting data to the Co-ordination Centre* by **20th August 2010**.
- The Care Quality Commission requests that trusts do not publish their survey results prior to the official release of CQC national and trust level results as there might be differences which could cause confusion for people. However, trusts can start using their results internally to identify areas for quality improvement.
- You must keep hard paper copies (or scanned images of all of the pages of the questionnaires, including the front page) of all questionnaires returned to you until **30th November 2010** but please **do not** send these to the Co-ordination Centre. These returned questionnaires may be needed to audit the data sent to the Co-ordination Centre.

1.7 Why you need this guide

Trusts have the option of conducting the survey in house or using an approved contractor (see Section 4). Whichever route you take, you will need to address the guidance in sections 1 to 13 and 18 to 20 of this document. Sections 15, 16 and 17 cover the practicalities of mailing out the survey, following-up responses and processing data, and submitting it to the Co-ordination Centre. These sections will be most relevant to approved contractors, or trusts undertaking the surveys themselves.

2 Setting up a project team

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

We suggest:

- **Establishing a workgroup.** Put together a small team of people who are key stakeholders and involve them in decisions. Groups to consider include:
 - Board members
 - Doctors, midwives, nurses and other health care staff
 - Managers
 - Medical records personnel or Patient Administration System (PAS) staff
 - Patients and carers
 - Members of patient groups with a special interest in the trust
 - Caldicott Guardian
 - Staff or directors responsible for:
 - Midwifery
 - Clinical governance
 - Patient advice and liaison service (PALS)
 - Quality improvement
 - Strategic planning.
- **Involving the person responsible for drawing the patient sample** in planning meetings. It is essential that this person, and their line manager, understand the purpose of the survey and the importance of drawing the sample correctly.
- **Keeping everyone informed.** Notify as many people as possible about ideas and activities. All departments in the trust should be made aware when a survey is being conducted, in case patients contact the trust asking questions about the survey they have received.
- **Not overlooking front-line staff.** These people who have the most frequent direct contact with patients.

3 What's new for 2010?

Question bank tool: In addition to a 'core' questionnaire that contains the compulsory 77 questions, an online questionnaire compilation tool ('question bank') is available for the 2010 maternity survey. The question bank includes 64 optional questions for trusts to use in addition to the 'core' questions. This is discussed further in section 14 – *The Core and Question Bank*

Please note that a limit has been set on the maximum number of pages that can comprise the questionnaire booklet. This limit is set to 16 sides of A4 (please see section 3.1 for further details)

Questionnaire changes: There are a number of changes in the **2010 maternity questionnaire** since 2007 although these have been kept as minimal as possible to allow comparisons with the 2007 maternity survey to be made.

Eight new questions have been added to the core questionnaire:

- B9. Were you given information about the NHS Choices website?
- B22. If you contacted a midwife, were you given the help you needed?
- C10. Did you have skin to skin contact (*baby naked, directly on your chest or tummy*) with your baby shortly after the birth?
- C13. If you had a partner or a companion with you during your labour and delivery, were they made welcome by the staff?
- F2. If you contacted a midwife or health visitor, were you given the help you needed?
- F10. Were you given enough information about any emotional changes you might experience after the birth?
- G6. Do you have any of the following long-standing conditions?
- G7. Does this condition(s) cause you difficulty with any of the following?

One key change in 2010 is that free text numeric boxes have been replaced with response options to aid completion and data cleaning. Questions previously in a grid format have been split into individual questions to aid completion and to allow some to be placed as 'optional' questions in the bank. When published, the development report will contain complete documentation about all changes made to the questionnaire along with information about which questions may be comparable to the 2007 survey. This will be published on our website at <http://www.nhssurveys.org>.

Survey fieldwork period: Since the 2007 survey, the fieldwork period for the survey has increased to 19 weeks. The date for final submission of data is the **20th August 2010**. We strongly encourage all trusts and survey contractors to submit their samples within the first four weeks of the survey (5th to 30th April) to make the most of the fieldwork period and to collect returned questionnaires for as long as possible before submitting data. This is discussed further in Section 11 – *Final sample inspection by the Co-ordination Centre*.

Sample Size: The sampling period is ***all consecutive live births in February 2010***, so the sample size will vary by trust. Since the 2007 survey, the minimum sample size has **increased from 200 to 250**. This is to allow for women who are removed from the sample following DBS checks and to ensure that there is still a large enough sample to allow for meaningful statistical analysis. This is discussed further in Section 10.1 – *Compile a list of eligible women*.

NHS Trust code: The three character code to identify your organisation (Trust code) should be included in your sample file for this year's survey. This is discussed further in section 10.6 – *Creating the sample file*.

Actual delivery place: For the 2010 maternity survey, this should be coded using the National Codes, found in the NHS Data Dictionary provided by Connecting for Health. This is discussed further in Section 10.6– *Creating the sample file*.

Hard copies of documents: For the 2010 survey, we will require trusts to send two blank paper copies of the questionnaire, covering letter and reminder letters used to the Coordination centre on **the same date** that the data should be submitted i.e. **20th August 2010**.

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

Demographics Batch Service (DBS): The NHS National Strategic Tracing Service has been replaced by the Demographics Batch Trace. The DBS traces records against the Spine Personal Demographics Service (PDS). Sample lists will need to be checked for any maternal or infant deaths using this new service. The DBS uses a file transfer application to send and receive files and will not accept files sent by encrypted email or through the post on physical media. You will need to ensure you are familiar with the new method for submitting batch files to be checked.

PCT information: In the previous survey, the Co-ordination Centre requested “PCT codes of residence” for all women in the sample. This has changed for the 2010 survey and we now also require the PCT which referred the woman for acute maternity care. This is discussed in further detail in *Section 10.6 –Create the sample file*.

3.1 Important information to remember

Page limit: A limit has been set on the maximum number of pages that can comprise the questionnaire booklet. This limit is set to 16 sides of A4, i.e. pages 1-16. Previous research carried out by Picker Institute Europe has shown that a patient questionnaire with more than 16 pages can result in a dramatic decrease in response rate. We recommend a minimum font size 11 for all questions and response options.

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

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

Embargo on results: Trust-level findings for the national maternity survey 2010 should not be released outside of the trust until the national results are published by the Care Quality Commission. Please continue to use the results from your in-house survey teams or approved

contractor to improve services, but wait until the survey results for all trusts are published by the Care Quality Commission before promoting your results in any way (either on your website, in press releases or any other external publicity) to the local community and media. You will receive, along with communications staff in your trust, advance notice of the publication date and will have time to prepare for your local announcements once the embargo is lifted.

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

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

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

4.1 Costs

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

Staff time

This is one of the largest expenditures, but it is sometimes overlooked. Be sure to include the cost of staff time, including salary and fringe benefits, and time spent away from other work. Please note that weekly submission of response rates and helpline monitoring information will be required for each trust taking part in the maternity survey 2010, involving increased staff time for both trusts and contractors.

Stationery and postage

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

Freepost licence

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

Freephone service

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

Data entry

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

Design and production of reports

This requires a considerable amount of skilled staff time.

4.2 Internal resources

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

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

4.3 Timing

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

4.4 Quality and confidence in the findings

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

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

When you have decided who will carry out your survey, i.e. an in-house team or an approved contractor, you must inform the Co-ordination Centre by 19th March 2010.

5 Commissioning a survey from an approved contractor

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

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

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

Information about each of these organisations, including their prices, can be found on the [NHSSurveys website](#).

5.1 List of approved contractors

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

BMG Research

Contacts: Jenna Allen and Simon Maydew

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

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

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

Contact: Cheryl Kershaw and Aimi Blueman

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

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

GFK NOP

Contact: Sarah McHugh, Joy Mhonda and Lisa Endersbee

GFK NOP
Ludgate House
245 Blackfriars Road
London
SE1 9UL

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

Ipsos MORI

Contact: Kate Duxbury

Ipsos MORI
79-81 Borough Road
London
SE1 1FY

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

Marketing Sciences

Contact: Eileen Sutherland and Joy Owen

Marketing Sciences
8 Clement Street
Winchester
Hampshire
SO23 9DR

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

MSB Ltd

Contact: Don Porter

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

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

The National Centre for Social Research

Contacts: Marian Bolden

National Centre for Social Research
Kings House
103-135 Kings Road
Brentwood
Essex
CM14 4LX

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

Patient Dynamics

Contacts: Fiona Ware and Andrew Smith

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

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

Patient Perspective

Contact: Stephen Bruster and Chris Henderson

Standingford House
26 Cave Street
Oxford
OX4 1BA

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

Picker Institute Europe

Contacts: Bridget Hopwood and Amy Tallett

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

Tel: 01865 208100
Fax: 01865 208101
E-mail: bridget.hopwood@Pickereurope.ac.uk; amy.tallett@Pickereurope.ac.uk
Website: www.pickereurope.org

Quality Health

Contacts: Dr Reg Race, Kerry Hibberd and Mandy Moore

Quality Health Ltd
Unit 1
Holmewood Business Park
Holmewood
Chesterfield
S42 5US

Tel: 01246 856263
Fax: 01246 855897
Email: reg.race@quality-health.co.uk; kerry.hibberd@quality-health.co.uk;
mandy.moore@quality-health.co.uk
Website: www.quality-health.co.uk

SNAP surveys

Contact: Tamara Gooderham, Emma Williams and Ralph Sutcliffe

SNAP Surveys
Mead Court
Cooper Road
Thornbury
Bristol
BS35 3UW

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

5.2 Contracts with survey contractors

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

These can be found on the NHSSurveys website. The three documents that are available are:

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

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

.....

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

6 Data protection and confidentiality

When carrying out your survey, you will need to ensure that you comply with the Data Protection Act 1998, and ensure that all responses are kept confidential. You will also need to comply with the NHS Code of Practice on Confidentiality (2003), which incorporates the Caldicott principles². It is your legal responsibility to ensure that you meet any guarantees of anonymity or confidentiality made in covering letters and on the questionnaire form. It will also be necessary to establish appropriate contractual arrangements with any contractors (see Section 5.2 – *Contracts with survey contractors*). Your trust's Caldicott guardian and legal advisors should advise you on these matters.

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

Their website below has further information:

<http://www.dh.gov.uk/PolicyAndGuidance/InformationPolicy/PatientConfidentialityAndCaldicottGuardians/fs/en>

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

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

6.1 Statements of compliance with data protection

In-house surveys

Each NHS trust has a Caldicott Guardian responsible for overseeing proper use of patient data. If you are conducting the survey in-house then, before mailing out the sample, you must submit a formal declaration, signed by the Caldicott Guardian and survey lead(s) for the trust, to the Co-ordination Centre. This declaration will certify that data shall only be displayed, reported, or disseminated in compliance with the new guidelines (see Section 6.8). Templates for these declarations are available on the website containing the survey guidance (<http://www.nhssurveys.org/surveys/488>).

² Each NHS trust has a Caldicott Guardian who is responsible for overseeing proper use of patient data. They have to ensure that any use of patient data conforms to the following principles:

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

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

You must wait for confirmation of receipt from the Co-ordination Centre before you mail out your sample.

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

Approved contractors

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

6.2 Keeping patient mailing data and sample data separate

Keeping names and addresses separate from either sample information or respondent data is the best way to ensure that the patient responses cannot be matched to patients who made them. For this reason, we suggest that once the sample has been returned from DBS and the list of patients are finalised, patient names, addresses and postcodes are removed from the sample file to a "Maternity 2010_mailing data" file. Before this is done, it is essential each patient is provided with a unique number (a patient reference number) and that this number is available and correctly matched on both the "Maternity 2010_mailing data" file and the sample information file.

6.3 Mailing questionnaires to patients

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

1. The contractor delivers pre-packed serial-numbered envelopes containing questionnaires, covering letters and FREEPOST envelopes to the trust. The trust then attaches number-matched address labels to the envelopes and sends them out to patients. Completed questionnaires can then be returned to the contractor and, by checking the record numbers on returned questionnaires, they can inform the trust which patients need to be sent reminders. This process is described in more detail in Section 16.
2. Alternatively, with the agreement of the trust's Caldicott Guardian, you may set up a written agreement between the trust and the external contractor to share patient contact details. The Care Quality Commission will provide a set of contracts for trusts and approved contractors carrying out the survey to avoid the need for each trust to develop its own arrangements. It is strongly recommended that these documents are reviewed by each trust and approved contractor to ensure they are satisfied with them, and to amend where required.

A model service contract and supporting guidance notes are available on our website <http://www.nhssurveys.org/surveys/487>

6.4 Patients' names and addresses

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

- Trusts/contractors must undertake to keep their products up to date to ensure that security is effective and must strictly observe the following guidance. The requirements that dictate the guidelines include the Data Protection Act 1998, the Health and Social Care Act (Community Health and Standards) Act 2003, the NHS confidentiality code of practice 2003³ (which incorporates the Caldicott principles).
- The Care Quality Commission strongly recommends that personal data such as names and addresses must be sent by trusts to contractors securely, either by post or over the Internet using an encrypted session.
- **By post:** Trusts should send the personal data to their contractor in the form of an encrypted data file. We strongly recommend that the **256-bit AES** (Advanced Encryption Standard) encryption algorithm should be used for this purpose – see below for further information on this. The password should be verbally given to a named individual at the contractor. **Passwords should never be written on CD-ROMs or diskettes or otherwise included with encrypted material sent through the post.** The encrypted database should be saved onto a CD-ROM or diskette, place it in a single sealed envelope or other container, annotated "Addressee only", and this should be sent to the contractor by Royal Mail Special Delivery or through an approved courier service⁴: personal data should **not** be sent by recorded delivery.
- **Over the Internet:** An encrypted session based on the Transport Layer Security (TLS) or Secure Sockets Layer (SSL) protocol (for example as with HTTPS or SFTP) must be used. A key size of 256 bits or greater should be used. This is to ensure a high level of security, to protect against any accidental or intentional interception during the transfer of patients' details. Approved contractors should be able to provide guidance on the use of an encrypted session to Trusts.
- As the owners of the data, the method for transferring patient samples is ultimately the Trust's decision because the Trust remains legally responsible for the security and processing of the information it shares. The Care Quality Commission strongly recommends the two methods described above. Trusts wishing to send information by encrypted email will need to seek their own specialist advice. Guidance on best practice in encryption is available from NHS Connecting for Health⁵.

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

6.5 Encryption of personal data

Any patient identifiable information sent between trusts and contractors should be in an encrypted format with password protection to help ensure good standards of information security. Many different encryption algorithms exist and not all of these are suitable, so both the Coordination Centre and the Care Quality Commission very strongly recommend the use of the **256-bit AES**

³ http://www.dh.gov.uk/prod_consum_dh/idcplg?IdcService=GET_FILE&dID=9722&Rendition=Web

⁴ Contact the Care Quality Commission for more detail on approved couriers: patient.survey@cqc.org.uk

⁵ http://www.connectingforhealth.nhs.uk/igsecurity/gpg/gpg/NPFIT-FNT-TO-IG-GPG-0004.01%20GPG_%20%20NHS%20Cryptographic%20Algorithms.pdf

(Advanced Encryption Standard) algorithm. There are several software tools that can be used to encrypt data in this way, the most commonly available of these being WinZip® (v9 and above)⁶.

6.6 Model contract

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

The model contract in Word format is available under the Maternity section of the website containing the survey guidance (<http://www.nhssurveys.org/surveys/491>)

6.7 Patient anonymity

In-house surveys

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

Approved contractors

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

6.8 Patient confidentiality

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

⁶ <http://www.winzip.com/>

Trust level

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

B7. Before your baby was born, did you plan to have your baby at home?			
Ethnic category	Yes	No	Total responses
	%	%	n
White	81	19	261
Mixed	-	-	8
Asian	-	-	18
Black	79	21	52
Chinese or other	85	15	36

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

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

Approved contractor

- 1) Approved contractors must not provide raw data to the trust as a matter of course.
- 2) If the trust has a particular need for the raw data from the survey from the approved contractor, the contractor may provide an abridged version of this dataset to the trust upon request, providing that the steps below are undertaken first:
 - a. The contractor must delete the two variables pertaining to **date of delivery** (e.g. both sample variable and response variable – A2)
 - b. The contractor must delete the two variables pertaining to **ethnicity** (e.g. both sample variable and response variable – G8)
 - c. The contractor must delete the responses to question **A1** on whether the woman gave birth to a single baby or more.
 - d. The contractor must delete the responses to questions **G1 and G2** on the woman's reproductive history
 - e. The contractor must delete the responses to question **G5** pertaining to the language spoken most often at home.
 - f. The contractor must **band the mother's year of birth** into five age groups (16-19, 20-24, 25-29, 30-34, 35+). This process should be repeated separately for both sample and response variables (G3). The original mother's year of birth variables (e.g. those specifying an exact year rather than age group) must then be deleted

- g. Verbatim comments that could lead to any staff identifying respondents must be removed, e.g. those mentioning dates and patient, staff, ward or unit names⁷
- h. Receive confirmation from the trust that they have destroyed the names and addresses of the sampled women, otherwise they will be able to identify individual women by matching up the patient record number/serial numbers on the name and address list to those in the raw data file.

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

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

	E3. Did you ever put your baby to the breast (even if it was only once)?		
Ethnic group	Yes	No	Total responses
	%	%	n
White	38	62	261
Mixed	-	-	8
Asian	-	-	18
Black	41	59	52
Chinese or other	85	15	36

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

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

6.9 Sharing of survey data between contractors

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

⁷ Please be aware that there are exemptions allowing disclosure, such as the prevention of crime exemption which **might** allow disclosure of free text describing criminal matters actual or threatened. Neither the Care Quality Commission nor the Co-ordination centre can offer legal advice on these matters; the contractor or trust must seek its own independent legal advice before disclosing patients' comments to trusts.

6.10 Storing completed questionnaires

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

7 Ethical issues, ethics committees and research governance

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

7.1 Ethical approval for the maternity survey

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

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

Your trust should notify the relevant R&D office that ethical approval has been obtained for the 2010 Maternity Survey. The MREC letter of approval can be found on our website.

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

7.2 Research governance requirements

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

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

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

The following table has been prepared by the Care Quality Commission and is taken from Section 3.10 of the *Research Governance Framework for health and social care (2005)*. The left-hand column sets out the responsibilities of organisations providing care and the right-hand columns sets out the arrangements made by the Care Quality Commission for patient surveys. If you are

required to seek approval from your research governance lead, you are advised to present this information to your Research and Development Manager in support of your request.

7.3 Responsibilities of NHS organisations who are carrying out research

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

Research Governance Framework	Care Quality Commission sponsored patient surveys
Ensure that, whenever they are to interact with individuals in a way, which has a direct bearing on the quality of their care, non-NHS employed researchers hold honorary NHS contracts and there is clear accountability and understanding of responsibilities. ⁸	<i>In situations where trusts opt to use the services of an external contractor to draw the sample for the survey, the contractor is required to enter into an honorary contract with the trust. These procedures are specifically detailed in the guidance notes.</i>
Put and keep in place systems to identify and learn from errors and failures.	<i>The Care Quality Commission also undertakes consultations with the trusts in order to ensure that the errors and failures are reported back to the Care Quality Commission. The survey programme is constantly evaluated and reviewed in the light of these.</i>
Put and keep in place systems to process, address and learn lessons from complaints arising from any research work being undertaken through or within the organisation.	<i>This requirement is not specific to this survey.</i>
Ensure that significant lessons learnt from complaints and from internal enquiries are communicated to funders, sponsors and other partners.	<i>The Care Quality Commission maintains a helpline facility, which can be used by patients or trusts to report any complaints. Similar arrangements are in place with the Co-ordination Centre who are commissioned by the Care Quality Commission to co-ordinate the patient surveys.</i>
Ensure that any research-related adverse events are included in reports to the National Patient Safety Agency in line with the standard procedures of the organisation; or to the systems for adverse events reporting in social care.	<i>Not applicable to the patient survey. Patient safety is not compromised, this being a postal survey.</i>
Permit and assist with any monitoring, auditing or inspection required by relevant authorities.	<i>The results of the surveys are used for monitoring of core and developmental standards in the Annual Health Check.</i>

⁸ When universities and hospitals employ staff on joint or dual contracts, they are expected to make joint arrangements for accountability and management. See *A Review of Appraisal, Disciplinary and Reporting Arrangements for Senior NHS and University Staff with Academic and Clinical Duties*, a report to the Secretary of State for Education and Skills by Professor Sir Brian Follett and Michael Paulson-Ellis, September 2001 (The Follett Report).

8 Collecting data from non-English-speaking populations

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

For this survey, translated questionnaires are not being used since the costs of ensuring rigorous translation (including cognitively testing interpretation of translated questions) would be substantial. Furthermore, there is evidence that the uptake of translated questionnaires in similar patient survey research is very low. Therefore, the first contact with women will have to be in English.

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

- It is good practice to offer help or interpretation services to those who might require them. You can do this by subscribing to a specialist interpreting service, most of who offer telephone interpretation on a pay-as-you-go basis. This normally involves a three-way conversation between you (or your helpline operator), the patient and the interpreter. (Note that trusts may already have arrangements with such a service.) If you are a trust that intends to conduct the survey using an in-house team, and you do not have access to such a service, please contact the Co-ordination Centre for further advice
- A multi-language leaflet template is available on our site, and this can be included with your first and third mailings. Trusts and approved contractors can use this leaflet by inserting their appropriate helpline number. This gives directions in the 20 most common non-English languages spoken in England and also in EasyRead (routed to a separate number run by Mencap to help those with learning disabilities).
- Many households include at least **one competent English speaker** who can help the person 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 woman to answer the questions for herself.

9 Timetable

The time taken to complete the survey process will depend on many factors. The survey period for the maternity survey is 19 weeks, to allow enough time for the sample to be validated by midwives. We recommend making full use of this to maximise response from younger and black and minority ethnic (BME) groups as previous research shows that these groups take longer to respond⁹. The best way to optimise the length of available fieldwork is to ensure that you generate your sample promptly (i.e. within the recommended four week sample checking period) and mail out your questionnaire packs promptly once permission has been received. Dissemination of the results to all staff, and to the local community and media, can only start after the survey has been completed so this will take additional time to complete.

If you commission an approved contractor, much of the work will be done by them, but you will still have to be involved in some of the stages of the process, marked in **bold** in the table below. If you are using an approved contractor for the survey, they will provide you with a timetable that might differ slightly to the suggested time periods below. As long as the specified three mailings take place and data is submitted to the Co-ordination Centre no later than the **20th August 2010**, the timetable provided by the contractor should take precedence over the suggested intervals below.

Week	Task	See Section
1	Guidance and documents published	
2	Inform Co-ordination Centre who is carrying out your survey by 19th March 2010 (name of approved contractor or in-house)	3
2	Decide on questions to be included in the survey (i.e. select from question bank or use the core questionnaire)	14
2-3	Draw sample of women to be included in the survey	10
2-3	Check sample for deceased women and infants using hospital records	10.2
3-4	Depending on the accuracy of your hospital information systems, check sample with member(s) of the clinical midwifery team to ensure all women are eligible to participate in survey	10.3
4-5	Submit sample list to DBS to check for deceased women AND infants	10.4
5-8	Submit anonymised sample to Acute Co-ordination Centre before starting mailing process.	11
1-2	<i>If using an approved contractor, supply them with trust headed paper and a signature of a senior executive and, if appropriate, ensure that the honorary contract is signed</i>	6 & 15.2
1-3	Print questionnaires and covering letters	14
2	Set up FREEPOST address and helpline	16.1 & 16.2
2	Establish system for responding to telephone enquiries	16.2

⁹ For details of this research carried out by the Picker Institute Europe see: http://www.nhssurveys.org/Filestore/documents/Extension_of_fieldwork_for_inpatient_survey_2007.pdf

3	Establish system for booking in questionnaires	16.5
6	Check your own trust's records again for any maternal or infant deaths	10.2
6-8	Stick labels on pre-packed numbered questionnaires and reminders supplied by approved contractor (if NOT using model contract)	4 & 14.6
6-9	Send out first questionnaires	15.3
6	Send first weekly response rate and helpline monitoring form to Acute Co-ordination Centre (15th April 2010)	12
6-24	Continue to respond to telephone enquiries	
6-24	Log and process returned questionnaires	16.5
6-24	Enter data	17
8	Check your own trust's records again for any deaths	10.2
8-11	Send out first reminders to non-responders	16.6
9-12	Be prepared for a small peak in telephone calls as first reminders received	
11	Check your own trust's records for any deaths	10.2
11-14	Send out second reminders to non-responders	16.6
23	Complete data entry	17
24	Check data for errors	17.3
24	Send data to Acute Co-ordination Centre (by 20th August 2010 at the latest)	17.4
24	Send two copies of the questionnaire, all covering letters and a copy of the checklist to the Acute Co-ordination Centre (by 20th August 2010 at the latest)	17.4 & 17.5
24	Begin analysing trust's results and writing report	18 & 19
25	Disseminate results to staff	19 & 20
	You must keep hard paper copies (or scanned images of all of the pages of the questionnaires, including the front page) of all questionnaires returned to you until 30th November 2010	6.10

10 Compiling a list of women

This section explains how to draw a sample of women. This task will need to be carried out by a member of staff at the NHS Trust. The sample will normally be drawn from the Patient Administration System (PAS). Depending on your trust's hospital information systems, it may be that sample information will need to be linked between the Patient Administration System (PAS) and the clinical maternity databases. In addition, maternal records will need to be linked to infants' records to apply some of the exclusion criteria, in which case support from an IT specialist may be required. The sample list will also need to be checked to make sure that the necessary exclusions have been applied and the list will also have to be checked by the Demographic Batch Service (DBS) to identify deceased women and infants.

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

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

10.1 Compile a list of eligible women

Compile a list of all women who had a live birth consecutively between **1st February and 28th February 2010**.

Note

If there are **less than 250 eligible women** who had a live birth in February, then please contact the Co-ordination Centre on 01865 208127 for advice on including women who gave birth in January 2010. Please note that the *minimum* sample size has increased to 250 from 200 in the 2007 survey

The information you obtain about each woman will be used both for administering the survey and for sending to the tracing service (DBS) to check for any deaths. It saves time and effort if all the information is gathered at the same time [See section 10.6 for a list of the data fields that you will need to include in your sample file for the survey].

The list should **include**:

- All women **aged 16 years or over** at the time of delivery, who have had a live birth within the trust, irrespective of which facility they use.¹⁰ Women who gave birth at a separate maternity unit should still be included in the sample.
- **All types of deliveries:** It is important that all women who had a baby in the time period are included in the survey, not just the ones with normal vaginal deliveries with no complications.
- **Multiparous and primiparous women:** Your sample should include both first-time mothers and women who had previously had a baby
- **Women who delivered at home.** If home births are not recorded on the hospital information system, it will require a manual check of the records held by midwives.
- Include women even if their addresses are incomplete but still useable (e.g. no postcode).

¹⁰ Exclude any women whose baby was born in a unit managed by a Primary Care Trust if these cases are also included on your hospital databases.

Exclusion criteria

The following women are **not** eligible to participate in the survey and should be **excluded** from your sample list:

- women who are under age 16 at the time of delivery
- women who had any of the following ICD10 delivery outcomes **or their equivalents**¹¹:
 - Z37.1 Single stillbirth
 - Z37.3 Twins, one live; one stillbirth
 - Z37.4 Twins, both stillbirths
 - Z37.6 Other multiple births; some live; some stillbirths
 - Z37.7 Other multiple births, all stillbirths
- women whose infants have died since delivery¹²
- women who have died during, or since, delivery
- women who are in hospital, or whose baby is in hospital, at the time of drawing the sample.
- where possible, women who had a concealed pregnancy¹³
- where possible, women whose baby was taken into care (i.e. foster care, adopted)¹⁴
- women who gave birth in a private maternity unit or wing
- women who gave birth in a maternity unit managed by a Primary Care Trust (PCT)
- women without a UK postal address (but do not exclude if addresses are incomplete e.g. no postcode)¹⁵

¹¹ If you do not use ICD10 codes in your systems, please use the appropriate equivalents to the codes listed above

¹² In order to apply this criterion, it is essential that maternal and infant records are linked. Death checks for infants will need to be run within the trust and by the DBS to ensure that deaths occurring both within the trust and outside trusts are detected.

¹³ If you do not record this information in your electronic systems, these women should be removed from the sample when the list is validated by member(s) of the midwifery team.

¹⁴ If you do not record this information in your electronic systems, these women should be removed from the sample when the list is validated by member(s) of the midwifery team.

¹⁵ Women whose address is in the British Islands (Isle of Man, the Channel Islands) are eligible for inclusion in the survey'

10.2 Checks carried out by the trust

Once you have compiled your list of women, you should carry out the following checks before you send the list to the Demographic Batch Service to carry out a further check for deceased women or infants.

- **Delivery outcome.** Check that all women in the sample had a live birth
- **Deceased mothers or infants.** Check that all women and their infants were discharged from the trust alive and that the trust does not have a record of either person's death from a subsequent admission or visit to the hospital. **This is an essential step to ensure that women and/or their families are not further traumatised by receiving a questionnaire asking about their pregnancy.**

Checks for deceased women and infants

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

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

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

You are also advised to repeat this check before the second and third mailings, and to ensure that approved contractors are advised immediately if any women in the sample – or their baby - die during the survey period.

- **Women's ages.** Check that all women are aged 16 or over at the time of delivery.
- **Concealed pregnancy.** Exclude any women who are known to have had a concealed pregnancy.
- **Babies taken into care.** Exclude any women who are known to have had their baby taken into care.
- **Private maternity care.** Remove any women treated as private patients from the sample
- **Postal addresses.** Exclude any women with addresses that are outside the UK.
- **Incomplete information.** Check for any records with incomplete information on key fields (such as surname and address) and remove those women. However, do not exclude anyone simply because you do not have a postcode for them. Only remove a woman if there is insufficient name or address information for the questionnaire to have a reasonable chance of being delivered. The more cases that are removed at this stage, the poorer the sample coverage and the greater the danger of bias.
- **Duplications.** Check that the same woman has not been included more than once.

10.3 Validating the sample

There is always a possibility that a patient's record has been incorrectly coded on the hospital's information system. To ensure that all women in the sample are eligible to participate in the survey, we recommend that once the list is drawn it is given to member(s) of the clinical midwifery team to check that the following women are not included: women who had a stillbirth; women whose baby has died following the birth; women who had a concealed pregnancy and/or women whose baby was taken into care.

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

Before sending out the questionnaires, the list of **women and their infants** should be checked for any deaths by the Demographics Batch Service (DBS).

The DBS has replaced the NHS Strategic Tracing Service (NSTS) batch trace. The DBS enables users to submit and receive a file containing relevant patient records electronically using dedicated client software. The patient records in the file are matched against the NHS Spine Personal Demographics Service (PDS).¹⁶

Create a trace request file

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

For each woman and their infant(s) you will need to include as a minimum:

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

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

Note

Infant details should be recorded on separate rows on the file that is submitted to DBS. If a woman gave birth to more than one baby (ie twins or more), then the details of each baby should be given on a separate row. The number of rows in the spreadsheet will therefore be at least double the number of women in the sample.

¹⁶ The PDS is a national electronic database of NHS patient demographic details. The PDS does not hold any clinical or sensitive data such as ethnicity or religion.

Submitting the trace request file

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

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

The response file

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

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

Further information is available from:

<http://www.connectingforhealth.nhs.uk/newsroom/news-stories/dbs270707>

Note

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

10.5 When the patient file is returned from DBS

The trace response file returned from DBS can be used to identify any women and/or babies that have died (indicated by a letter 'D') and therefore need to be deleted from the sample file. **If an infant has died but their mother is still alive, that record must be removed from the list.** This may reduce the numbers in your sample list slightly.

Important note: Due to the sensitivity of the maternity survey, please **exclude** any women from the sample if they (or their baby) could not be traced. If there are more than 5 records which are untraced, and therefore need to be removed from the sample, please contact the Co-ordination Centre for advice (advice@pickereurope.ac.uk or 01865 208127).

10.6 Create the sample file

An example of the spreadsheet you should complete has been included below. **This is available to be downloaded from our site (www.NHSSurveys.org) and is entitled “Sample construction spreadsheet”.** The column headings will match to the validated spreadsheet for final submission of data produced by the Co-ordination Centre and so it will be advantageous for you to use this spreadsheet. Save this file as <NHStrustname>_Maternity2010.

This file has three purposes:

- 1) It will be used to keep a record of which women have not returned questionnaires so that reminders can be sent to them.
- 2) It will be used to generate weekly response rates for your trust that must be forwarded to the Co-ordination Centre every Thursday from the **15th April 2010** until the closing date of the survey.
- 3) The anonymous data in this file (i.e. all the data **except** women’s name and address information) will form part of the file that you will submit to the Co-ordination Centre when the survey is completed.

Table 1 – Example: Sample construction spreadsheet

<i>Record number</i>	<i>Trust code</i>	<i>Title</i>	<i>Initials</i>	<i>Surname</i>	<i>Address1</i>	<i>Address5</i>	<i>Postcode</i>	<i>Mother's Year of birth</i>	<i>Mother's Ethnic Group</i>	<i>Day of delivery</i>	<i>Month of delivery</i>	<i>Year of delivery</i>	<i>Actual Delivery Place</i>	<i>Place of birth: NHS Site code</i>	<i>PCT of Residence</i>	<i>Referring PCT</i>	<i>Day of questionnaire being received</i>	<i>Month of questionnaire being received</i>	<i>Year of questionnaire being received</i>	<i>Outcome</i>	<i>Comments</i>
1001	RNH	Miss	AM	Abbot			AB1 1YZ	1969	A	1	2	2010	2	RR115	5LS	5LS				3	Informed that woman's baby had died
1002	RNH	Mrs	EC	Ahmed			AB2 6XZ	1978	J	3	2	2010	0	RTE03	5LT	5LT	14	05	2010	1	
1003	RNH	Ms	P	Lane			AB3 8PL	1989	B	3	2	2010	2	RR115	5LP					4	
1339	RNH	Ms	K	Yoo			AB4 7MX	1982	R	27	2	2010	1		5LS	5LS					
1340	RNH	Ms	F	Young			AB9 5ZX	1975	A	28	2	2010	0	RTE03	5GT	5GT	19	06	2010	1	

Important note about table 1

The headings of Table 1 are in three different colours:

Bold black headings: these columns contain information on womens' names, addresses and comments that may allow them to be identified. This information should be deleted from all files sent to the Acute Co-ordination Centre

Red italic headings: these columns should be completed during the sampling phase and submitted to the Acute Co-ordination Centre prior to mailing for final inspection (see Section 11) and at the conclusion of the survey

Green italic headings: these columns should be completed when the woman responds to the survey, either by returning a completed questionnaire, or the trust is notified the woman will not be participating (deceased, moved address, too ill, or called to opt out).

The following information is compiled using hospital records:

- **Trust code** should be the three character code of your organisation (e.g. RNH), maintained by NHS Connecting for Health¹⁷
- Title (Ms, Mrs, Miss, etc)
- Initials (or First name)
- Surname
- Address Fields¹⁸
- Postcode
- The mother's **Year of Birth** should be included in the form of NNNN.
- The mother's **Ethnic Group**¹⁹ should be coded using the 17 item alphabetical coding specified by NHS Connecting for Health²⁰. The codes are as follow:

National Codes:

White

A	British
B	Irish
C	Any other White background

Mixed

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

Asian or Asian British

H	Indian
---	--------

¹⁷ A data file of NHS Organisation Codes can be downloaded from the Organisation Data Service on the Connecting for Health website (www.connectingforhealth.nhs.uk/systemsandservices/data/ods/data-files)

¹⁸ The address should be held as separate fields (eg street, area, town, and county), consistent with the address format required by the DBS (formally NSTS).

¹⁹ It is acknowledged that hospital records might not always contain complete data on womens' ethnic category. However, this field should be included wherever possible. This data is required in order to evaluate non-response from different ethnic categories. This is in keeping with the aims of the Care Quality Commission and Department of Health to be more responsive to all ethnic groups and to ensure all groups are appropriately represented in their assessments.

²⁰ These codes can be found in the NHS Data Dictionary provided by Connecting for Health on the following website:
http://www.datadictionary.nhs.uk/data_dictionary/attributes/e/enh/ethnic_category_code_de.asp?shownav=1

J	Pakistani
K	Bangladeshi
L	Any other Asian background

Black or Black British

M	Caribbean
N	African
P	Any other Black background

Other Ethnic Groups

R	Chinese
S	Any other ethnic group
Z	Not stated

NOTE

The ethnic code 'Z' should be used **only** when a person has been asked for their ethnic category and had declined either because of refusal or genuine inability to choose. A blank or full-stop should still be used to indicate where ethnic category is "not known" i.e. where the woman had not been asked or she was not in a condition to be asked, e.g. unconscious. For most trusts, ethnic category will contain both "Z" **and** "blanks".

Some trust's information systems do not distinguish between ethnic codes of 'not known' and 'not stated'. If this is the case for your trust, please code all women for whom no ethnicity data is known as 'not known' by leaving this data field blank. Only women who have been asked to provide their ethnic category but have declined to state this information should be coded as 'not stated' using code 'Z'

- **Day** of delivery (1 or 2 digits, e.g. 7 or 26)
- **Month** of delivery (1 digit, i.e. 1 or 2)
- **Year** of delivery (4 digits; i.e. 2010)*
- **Actual delivery place:** should be coded using the National Codes²¹:
 - 1 At a domestic address
 - 2 In NHS hospital - delivery facilities associated with CONSULTANT ward
 - 3 In NHS hospital - delivery facilities associated with GENERAL MEDICAL PRACTITIONER ward
 - 0 In NHS hospital - delivery facilities associated with MIDWIFE ward
 - 4 In NHS hospital - delivery facilities associated with CONSULTANT/ GENERAL MEDICAL PRACTITIONER/ MIDWIFE ward inclusive of any combination of two of the professionals mentioned
 - 7 In NHS hospital - ward or unit without delivery facilities
 - 6 In other hospital or institution
 - 8 None of the above
 - 9 Not known

²¹ The 'Actual place of delivery' codes can be found in the NHS Data Dictionary provided by Connecting for Health on the following website:
http://www.datadictionary.nhs.uk/data_dictionary/attributes/a/acc/actual_delivery_place_de.asp?shownav=1

- **NHS Site Code** of where the baby was delivered (i.e. to identify which hospital or maternity unit) should be coded using the five character NHS Trust Site Codes (maintained by NHS Connecting for Health)²². This cell should be left blank for any deliveries that were not in hospital (i.e. where the ‘actual delivery place’ is coded 1 or 8)
- **PCT of Residence** should be coded using the **first three** characters of the PCT character codes (maintained by the Organisation Data Service –NHS Connecting for Health²³). They provide postcode files which link postcodes to the PCTs.
- **Referring PCT** should be coded using the **first three** characters of the PCT character codes of the PCT which will be billed for the care of that patient. For the most up-to-date list of PCT codes, please see the Connecting For Health data set, “Primary Care Trusts” (<http://www.connectingforhealth.nhs.uk/systemsandservices/data/ods/data-files>)

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

- 1) **Record number.** This field will be a series of consecutive whole numbers (for example, 1001 through to 1340). This number is unique for each woman. It can be seen in the example that the numbers are in ascending order, starting at 1001 at the top of the list, through to 1340 at the bottom. The record number will be included on address labels and on questionnaires. Later, when questionnaires are returned (whether completed or not), you (or the approved contractor) will be able to use these numbers to monitor which women have returned their questionnaires and to identify any non-responders, who will need to be sent reminders. If an approved contractor is used, you will need to agree with them on the range of serial numbers that will be used for your women.
- 2) **Day of questionnaire being received.** This can only be completed if and when a questionnaire is received by the trust or approved contractor. It should be a one or two digit numerical response e.g. N or NN, **not** a date format e.g. 12/07/10.
- 3) **Month of questionnaire being received.** This can only be completed if and when a questionnaire is received by the trusts or approved contractor. It should be a one or two digit numerical response, **not** a date format.
- 4) **Year of questionnaire being received.** This can only be completed if and when a questionnaire is received by the trusts or approved contractor. It should be a four digit numerical response, **not** a date format.
- 5) The **Outcome** field will be used to record which questionnaires are returned to the freepost address, or are returned undelivered, or which women opt out of the survey, etc.
 - 1 = Returned useable questionnaire
 - 2 = Returned undelivered by the mail service or woman moved house
 - 3 = Woman or baby died
 - 4 = Woman reported too ill to complete questionnaire, opted out or returned blank questionnaire
 - 5 = Woman was not eligible to fill in questionnaire
 - 6 = Questionnaire not returned (reason not known).

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

²² A data file of NHS Trust Site Codes can be downloaded from the Organisation Data Service on the Connecting for Health website (<http://www.connectingforhealth.nhs.uk/systemsandservices/data/ods>)

²³ See <http://www.connectingforhealth.nhs.uk/systemsandservices/data/ods> for further details.

10.7 Distribution of ages

You should check that women of all ages are included in your sample, especially for those aged 16, 17 or 18 years. We have found this age group is the most likely to be excluded due to poor sampling. It is possible there may not be any young women in your sample, but this should be confirmed by checking your original sample (before exclusion criteria were applied) and your sampling techniques. Check that your sampled women's ages cover the full range of expected ages. Ideally, you should do this by checking the distribution of ages on a histogram (See Figure 1). For most trusts the histogram is likely to start with a relatively small number of women aged under 20 years, and then rise steeply and form a plateau (representing a large number of women aged between 25 and 35 years) before entering a fairly gradual decline, with a small number of women aged over 40 years

Figure 1 - Age Histogram for 2007 Maternity Survey

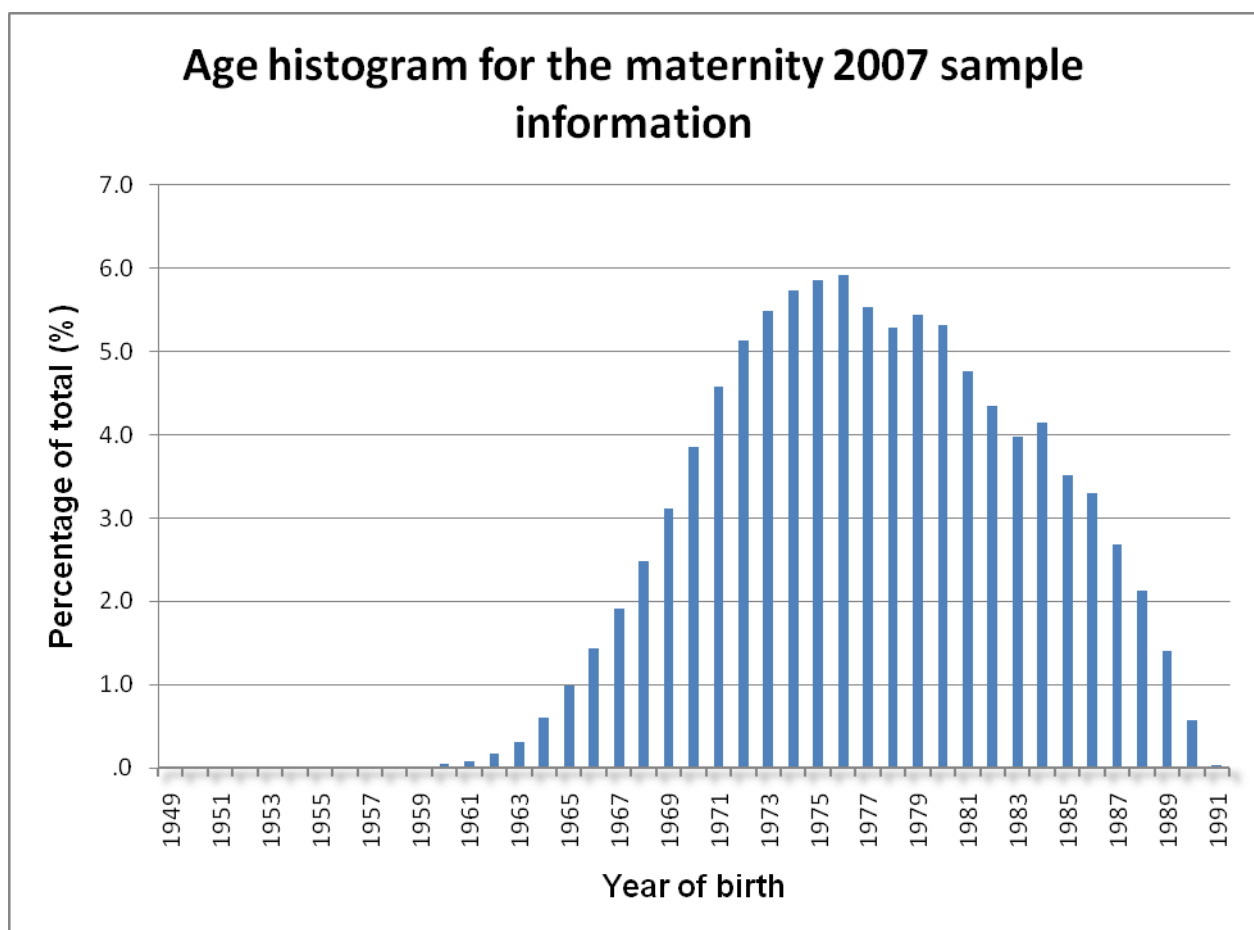


Figure 1 - Age Histogram for 2007 Maternity Survey

10.8 Separating mailing details from sample information

At this point you should transfer the names, address and postcode for each woman in the sample to a new file. The record number for each woman should be copied to the new file, so that the two datasets are connected using the unique record number. It is essential to ensure this number is correctly applied to the two datasets. Save this new file as “Maternity2010_mailing data”.

This file should be used for mailing purposes: it will be used to check for deceased women & infants prior to reminder mailings and will be cross-referenced with the sample file (<NHStrustname>_Maternity2010) to identify women who will need to be sent reminders.²⁴

As this “Maternity2010_mailing data” file will only be used occasionally during the survey, we recommend you keep this file encrypted. The mailing data file should be destroyed when the last mailing process is complete.

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

Table 3 – Example mailing file

<i>Patient record number</i>	Title	Initials	Surname	Address1	Address2	Address3	Address4	Address5	Postcode
1001	Mrs	AM	Abbot	14 Station Road	London				AB1 1YZ
1002	Mr	EC	Ahmed	Flat 7	Short Street	Oxford			AB2 6XZ
					--				
1339	Ms	K	Yoo	The Maltings	Birch Road	Little Abington	Cambridge	Cambs	AB4 7MX
1340	Ms	F	Young	634 Tyne Road	Moorfields	Tyne and Wear			AB9 5ZX

²⁴ As shown in Table 1, the ‘outcome’ field in the sample file is used to record which questionnaires are returned completed, or are returned undelivered, or which patients opt out etc...

10.9 Sharing the sample file with an approved contractor

If you are working with an approved contractor and have a contract in place relating to the transfer of patient identifiable information (i.e. women's names and addresses) both the sample file ("**<NHStrustname>_Maternity2010**") **and** the mailing file ("Maternity2010_mailing data") file should be sent to the contractor staff in encrypted format (see *Section 6.5 - Encryption of personal data*).

If you are working with an approved contractor, but have chosen to mail out the questionnaires yourself, within the trust, you should supply them with just the sample file (this will resemble **Table 1 – Example: Sample construction spreadsheet** but with the women's names, addresses and postcodes removed). The contractor can use this list to record the outcome codes, but you should ensure that the contractor is kept up to date with any information that comes directly to the trust about maternal or infant deaths, etc.

10.10 Making more use of the survey locally

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

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

- Analyse or compare results for specific subgroups (for example, women who gave birth at different maternity units or women of different ethnicities) in more detail than would be possible from this sample. By increasing the sample size you can ensure that you have a large enough sample of women from each group²⁵
- Cover a very wide range of questions without exceeding the maximum questionnaire length of 16 pages for the main survey. If you wish to ask a large number of questions from the question bank, it would be possible to use two different versions of the questionnaire with a different selection of questions included, each going to a separate sample (please note however that all women in the core sample must receive an identical questionnaire which must include the core questions).
- Alternatively, if your trust manages a large number of deliveries, you may wish to draw an extra sample of women to survey additionally to those included in the main survey. For example, you could select women who gave birth in a different time period from those in the national survey and send them questionnaires either at the same time as or at some point after the national survey. By running the survey locally in addition to the national survey, you can establish a more frequent pattern of reporting enabling you to track experience over time, or test the impact of recent quality improvement initiatives. If you decide to carry out an maternity survey locally at the same time as the national survey you will need to ensure that you are sampling two distinct and separate groups of women which do not overlap. Guidance for carrying out a local survey, and all survey materials, will be made available at the end of May on our website at <http://www.nhssurveys.org/localsurveys>

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

²⁵ See section 18 for more information on the reliability of data based on different numbers of respondents.

- The core sample for the 2010 maternity survey **must** be drawn as specified in this guide; any deviation from the guidance may make it impossible for the Care Quality Commission to use the data that you collect. It is therefore essential that any additional sample drawn can be easily distinguished from the core sample, and that it is drawn in such a way as to not interfere with selection of the core sample.
- If you are planning to undertake surveys more frequently than the national programme, then you should consider how any increased sample here will fit with the additional surveys you will be undertaking. Guidance for carrying out local surveys is available on our website at: www.nhssurveys.org/localsurveys .

To summarise

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

You must **only** send the Co-ordination Centre data for the women sampled according to these guidelines, and these women **must** be those who gave birth in February. If you decide to carry out a maternity survey locally at the same time as the national survey you will need to ensure that you are sampling two distinct and separate groups of women which do not overlap.

11 Final sampling inspection by the Co-ordination Centre

Trust data should still be checked for errors and received back from DBS before being forwarded to the Co-ordination Centre. An anonymised sample file²⁶ **must** be submitted to the Co-ordination Centre **prior** to the first mailing. This is to allow us to make final quality control checks. All columns *in red italics* in **Table 1 Example: Sample construction spreadsheet** must be submitted, but name, address and postcode details must be removed.

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

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

Your first mailing should take place as soon as possible after your sample has been approved by the Co-ordination Centre but **must not be later than seven days** after this. A large time lag increases the likelihood of women (or their babies) having died between the sample file being received back from DBS and the questionnaire being received, increasing the risk of distress to family members and complaints to your trust.

Making the most of the fieldwork period

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

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

²⁶ Created by removing the womens' names, addresses and postcodes.

For the 2010 maternity survey, the specified sample submission dates are:

Date sample received	Date sample returned
5 th – 9 th April 2010	12 th April 2010
13 th – 16 th April 2010	19 th April 2010
20 th – 23 rd April 2010	26 th April 2010
27 th – 30 th April 2010	4 th May 2010 ²⁷

Samples should be submitted to the Co-ordination Centre by the **30th April 2010**. If they are not, there is a risk your trust will not have enough time to correct any problems in the sample and complete the survey with an acceptable response rate. Major errors may then result in the data from the trust being excluded from the relevant Care Quality Commission assessments.

Trusts which have not submitted their sample for checking by the **30th April 2010** will be contacted by the Co-ordination Centre to discuss any problems you are having and how we can help with the process. However, if samples are not received by the **7th May 2010**, then we are required to notify the Care Quality Commission of this and they will contact you to discuss any implications for inclusion in Care Quality Commission produced data.

²⁷ Please note Monday 3rd May is a **bank holiday**, so samples will be returned on Tuesday 4th May.

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12 Weekly monitoring

The Co-ordination Centre requires weekly submissions of outcome data and helpline calls for each trust taking part in the 2010 maternity survey. First submission of data must be made on Thursday **15th April 2010²⁸**, and every Thursday thereafter until the final date of submission. An Excel spreadsheet is available on our website (www.nhssurveys.org) which **must** be used to return this information to the Co-ordination Centre. This information should be emailed to the Co-ordination Centre (maternity.data@pickereurope.ac.uk) by the end of the workday every Thursday throughout the survey.

Weekly submissions only apply to the core sample of patients

Important note

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

For trusts carrying out the survey in-house:

When the data is submitted, the file name **must** be in the following format:
MAT10_<trust code>_<week of submission>.xls

e.g. MAT10_RAC_1.xls (first submission of monitoring data on 15th April)
MAT10_RY2_4.xls (fourth submission of monitoring data on 6th May)

For approved contractors:

When the data is submitted, the file name **must** be in the following format:
MAT10_<contractor code>_<week of submission>.xls

e.g. MAT10_CDP_1.xls (first submission of monitoring data on 15th April)
MAT10_CYH_4.xls (fourth submission of monitoring data on 6th May)

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

12.1 Response rate

The information submitted should contain the following data:

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

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

²⁸ This submission must be made regardless of whether mailing has commenced.

12.2 Helpline monitoring

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

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

Examples

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

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

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

This information allows the Co-ordination Centre to identify areas of concern to people who have received the questionnaire and to improve future surveys.

13 Publicising the survey

13.1 Pre-survey communication with staff

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

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

Keeping everyone informed

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

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

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

Appendix 1 includes information which you can tailor for publicising the survey to staff.

13.2 Publicising the survey externally

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

- Send a press release to the local media to raise awareness of the survey and gain publicity just before the survey takes place. Talk to your hospital's press office for more ways in which you can gain publicity locally. *Appendix 2* includes information which you can tailor for publicising the survey externally.
- Put up posters in the maternity units/wards which show the importance the trust places on gathering women's feedback. To be most effective at increasing your response rate, posters should be put up in the hospital during the sampling period (i.e. during the month(s) from which your sample of women will be drawn). To encourage women to respond, we

recommend you illustrate how the trust has acted on the results of the previous maternity surveys carried out by the trust. Women are likely to be more motivated to take part in the survey if they can see tangible outcomes from a previous survey.

14 The core questions and question bank

Each trust must include in their survey at least the 77 compulsory ‘core’ questions. There is a pre-designed core questionnaire on the NHSSurveys website, which includes only these questions. Trusts can also choose to use an “enhanced” questionnaire, where additional questions of local relevance may be added from a question bank of validated questions. A questionnaire compilation tool is available on the NHS Surveys website to help you create your survey

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

- 1) The **core maternity questionnaire**, which comprises 77 core questions.
- 2) The **enhanced questionnaire**, which includes the 77 core questions, with additional questions added from the bank of validated questions.

14.1 The core questionnaire

The core questionnaire consists of 77 questions on 12 pages. These questions cover the issues that have been found to be most important to women and **must** be included in your survey. The front page of the questionnaire explains the purpose of the survey and gives instructions on how to fill it in. In the pages that follow, the survey questions are divided into sections that broadly follow the women’s maternity pathway.

14.2 Using the question bank

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

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

Deciding which questions to use

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

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

- **Comparison of results over time:** if you want to compare your results with the previous national maternity survey, then remember to select the questions you used before.
- **Evaluation of service improvement initiatives:** if you are implementing service improvements, you may wish to include questions which measure the success of these initiatives.
- **Monitoring progress against national targets / trust-wide initiatives**

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

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

Generating the questionnaire

Once you have selected all the questions you want to include in your survey, the questionnaire can be generated by clicking 'Generate PDF'. This produces a questionnaire in PDF format, which can then be saved on the website so you can return to it in future, saved to disk or printed out.

When you have finalised your questionnaire, remember to check the question numbering is consecutive and the 'Go to' instructions are correct.

The Care Quality Commission holds the **copyright** to the maternity survey tool. To protect this please:

- a) acknowledge in all published materials the Care Quality Commission's ownership of and copyright for the tool
- b) do not use the tool for generation of revenue

15 Materials

15.1 Printing questionnaires

Questionnaire layout

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

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

A1. Did you give birth to a single baby, twins or more in your most recent pregnancy?

- 1 A single baby
- 2 Twins
- 3 Triplets, quads or more

- Please do not arrange the response options horizontally across the page, rearrange the question options, or change the order of the questions in the questionnaire.
- Please ensure that the final questionnaire is **A4 size** (or A3 paper folded to make an A4 booklet)
- We recommend you use a font size of no less than 11

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 questionnaire, available in PDF format on the NHSSurveys website, is designed to fit onto 16 sides of A4 paper.

Number of questionnaires

When calculating the number of questionnaires to be printed, you will need to allow for sending out duplicate questionnaires with second reminders. Printing costs can be unnecessarily high if a second print-run is required, so it is worth ensuring that the first print-run is sufficiently large to allow for contingencies. As a rule of thumb, multiply the number of women in the sample by 1.7 to obtain the total number of questionnaires required. So, if the number of first mailing questionnaires you intend to send out is 350, then you might want to print 1.7 x 350, or approximately 600 copies.

Including other information in the mailing packs

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

15.2 Trust headed paper

You will need headed paper from your trust for covering letters for the first and third mailing. A reminder letter is used for the second mailing. If an approved contractor is being used to carry out the survey work, it is preferable that the paper does not include a telephone number for the trust, as patients should call the contractor's FREEPHONE line, rather than the trust.

15.3 First mailing

You will need each of the following items for each woman in the sample:

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

15.4 Second mailing (first reminder)

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

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

15.5 Third mailing (second reminder)

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

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

16 Implementing the survey - practicalities

16.1 Setting up a FREEPOST address

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

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

16.2 Setting up a FREEPHONE line

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

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

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

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

Women can be referred to the trust's PALS, the complaints manager or patient services manager. Approved contractors should be given the contact details of the PALS office or an appropriate member of trust staff so that they can refer callers to that person.

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

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

The woman (or her baby) to whom the questionnaire is addressed has died

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

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

If a woman's spoken English is better than their written English, they may be willing to have someone, such as a family member, fill in a form on their behalf. It is also strongly recommended that you offer access to a telephone interpretation service, where the questionnaire can be filled in over the telephone. A multi-language sheet template in the twenty most commonly spoken

languages in England is available on our website, and trusts or contractors can make use of this by inserting the appropriate number for their helpline and/or translation service.

I do not wish to participate in this survey

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

Making a record of the calls

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

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

16.3 Covering letters

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

16.4 Sending out questionnaires

Mailing labels

Three mailing labels are needed for each woman. 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 unique record number is on each address label**, as this has to be matched with the number on the front of the questionnaire. The label should not include any other information except the womens' names, address and postcode details, and the record number.

Note on the record number

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

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

Questionnaire packs

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

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

Postage

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

Approved contractors – mailing questionnaires

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

Approved contractors – trusts mailing questionnaires

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

16.5 Booking in questionnaires

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

Approved contractors

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

16.6 Sending out reminders

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

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

Approved contractors

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

First reminders

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

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

Second reminders

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

The envelopes should include the following:

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

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

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

17 Entering data

The data must be submitted to the Acute Co-ordination Centre in the appropriate format by the deadline of **20th August 2010**. If an approved contractor is used, they will be responsible for all of the data entry and checking, and when the survey is completed they should submit the data to the Acute Co-ordination Centre in the correct format and supply the trust with an anonymised data set (see Section 6 on data protection issues).

17.1 Entering and coding data from the questionnaire

The data should be entered into the pre-designed Excel file, which can be found in the maternity 2010 survey section of the NHSSurveys website.

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

- Each row records one woman's responses to the survey.
- For each question, the small number next to the box ticked should be entered as the response. (However, there are some exceptions to this rule – see last bullet point below).
- If a response is missing for any reason, it should be left blank, or coded as a full stop (.).²⁹
- If two boxes are ticked (where only one should be ticked), the response should be left blank or coded as a full stop (.).
- For most questions, each column corresponds to one survey question. However, there are some exceptions to this rule. For multiple response questions B12, C3, G6 and G7 that gives the instruction "Please tick all that apply", each response option is treated as a separate question.

²⁹ If you want to use this data input file on the website to display frequencies on the other pages of the workbook, you will need to fill in the blank cells with a full stop (.).

Example

B12. Which of the following health professionals did you see for your antenatal check-ups?
(Tick ALL that apply)

- 1 Midwife
- 2 GP (family doctor)
- 3 Hospital doctor (e.g. a consultant)
- 4 Other

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

Question B12 takes up four columns in the data file, labelled as follows:

Column headings	B12_1	B12_2	B12_3	B12_4
Codings for this example	1	0	1	0

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

17.2 Entering data from enhanced or customised questionnaires

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

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

You will need to send the data from **only** the 77 compulsory core maternity survey questions to the Co-ordination Centre. To do this, you will need to transfer those columns of data that cover the responses to those 77 questions to the pre-designed Excel file available on the website. The columns of this standard Excel file are headed with the numbers corresponding to the question numbers in the core maternity questionnaire. They also include the wordings of the 77 core maternity questions so that you can match them up. It is essential that you check carefully that the columns of data you select from any larger data set correspond to the 77 core maternity survey questions.

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

17.3 Checking the data for errors

For the 2010 maternity survey, trusts and contractors are required to submit raw ('uncleaned') data to the Coordination Centre. For clarification, raw data is created by the following:

- 1) All responses should be entered into the dataset, regardless of whether or not the respondent was meant to respond to the question (e.g. where women answer questions that they have been directed to skip past, these responses should still be entered).
- 2) Where a respondent has ticked more than one response category on a question, this should be set to missing in the data. The **exception** to this is for the 'multiple response' questions B12, C3, G6 and G7 where respondents may tick more than one response option.
- 3) Where a respondent has crossed out a response, this should not be entered in the data. Where a respondent has crossed out a response and instead ticked a second response option, this second choice should be entered into the data.
- 4) Where a respondent has given their response inconsistently with the formatting of the questionnaire but where their intended response is nonetheless unambiguous on inspection of the completed questionnaire, then the respondent's intended response should be entered. For example, where a woman has written their date of birth in the boxes for question G3, but written their year of birth in at the side of this, then the respondent's year of birth should be entered.
- 5) For the year of birth question, unrealistic responses should still be entered except following rule 4) above. For example, if a respondent enters '2010' in the year of birth box, this should still be entered unless the respondent has unambiguously indicated their actual year of birth to the side.
- 6) Once the data has been entered, no responses should be removed or changed in any way except where responses are known to have been entered incorrectly or where inspection of the questionnaire indicates that the patient's intended response has not been captured. This includes 'out-of-range' responses, which must not be automatically removed from the dataset. Responses in the dataset should only be changed before submission to the Acute Coordination Centre where they are found to have been entered inconsistently with the respondent's intended response.

17.4 Submitting data to the Acute Co-ordination Centre

The data from the core questions of the 2010 maternity survey must be supplied to the Acute Co-ordination Centre as one anonymised Excel file that includes information about the patient sample and responses. To comply with the Data Protection Act, name and address details must not be sent to the Co-ordination Centre.

Required file format

Please submit the file to the following specifications:

- Use Microsoft Excel Worksheet (not Workbook). Any version of Excel is acceptable.
- The file name must be in the form <NHStrustName>_Maternity2010.xls.
- Use one row of data for each woman in the sample.
- Use one column of data for each item of information or response.
- Respondents who are missing their unique 'Record Numbers' should be added to the bottom of the list, and not matched to women with similar demographics

- Missing data should be left blank or coded as a full stop (.).³⁰

Table 2 shows the information that must be provided for each woman in the original sample.

Table 2 – Data fields to be included in file submitted to Co-ordination Centre

Field	Format	Data codes	Comments
Unique Record number	N, NN, NNN or NNNN		The unique serial number allocated to each woman by the trust or approved contractor administering the survey.
Trust code	NNN		This is the NHS organisation code (e.g. RNH) as maintained by NHS Connecting for Health
Mother's Year of birth	NNNN		Format this simply as a number, not in date format.
Mother's Ethnic Group	N	<p>National Codes:</p> <p>White A British B Irish C Any other White background</p> <p>Mixed D White and Black Caribbean E White and Black African F White and Asian G Any other mixed background</p> <p>Asian or Asian British H Indian J Pakistani K Bangladeshi L Any other Asian background</p> <p>Black or Black British M Caribbean N African P Any other Black background</p> <p>Other Ethnic Groups R Chinese S Any other ethnic group</p> <p>Z Not stated</p>	Ethnic category should be included if the information is available.

³⁰ Data may be missing for a number of reasons. The woman may have skipped a question or a set of questions by following instructions; a woman may have not answered for some other reason. However, all missing data should be left blank or coded as a full stop (.), regardless of the reason for the omission.

Field	Format	Data codes	Comments
Day of delivery	N or NN		For example, if the woman gave birth on February 15th 2010 this column should read 15.
Month of delivery	N or NN		For example, if the woman gave birth on February 15th 2010, this column should read 2.
Year of delivery	NNNN		For example, if the woman gave birth on February 15th 2010, this column should read 2010.
Actual delivery place	N	<p>1 At a domestic address</p> <p>2 In NHS hospital - delivery facilities associated with CONSULTANT ward</p> <p>3 In NHS hospital - delivery facilities associated with GENERAL MEDICAL PRACTITIONER ward</p> <p>0 In NHS hospital - delivery facilities associated with MIDWIFE ward</p> <p>4 In NHS hospital - delivery facilities associated with CONSULTANT/ GENERAL MEDICAL PRACTITIONER/ MIDWIFE ward inclusive of any combination of two of the professionals mentioned</p> <p>7 In NHS hospital - ward or unit without delivery facilities</p> <p>6 In other hospital or institution</p> <p>8 None of the above</p> <p>9 Not known</p>	This should be coded using the National Codes (These codes can be found in the NHS Data Dictionary provided by Connecting for Health ³¹)
Place of birth: NHS Site Code	NNNNN	Use the NHS Trust Site Codes maintained by Organisation Data Service (NHS Connecting for Health)	For example, RR115. This cell should be left blank for any deliveries that were not in hospital (i.e. where the 'actual delivery place' is coded 1 or 8)
PCT of Residence	NNN	Use the character codes maintained by Connecting for Health to complete this field	Only use the FIRST three characters of the PCT of residence code
Referring PCT	NNN	Use the character codes provided by Connecting for Health to complete this field	Only use the FIRST three characters of the PCT code
Day of receiving	N or NN	This is the day you received a returned questionnaire from a	For example, if the questionnaire was received on May 17th 2010,

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http://www.datadictionary.nhs.uk/data_dictionary/attributes/a/acc/actual_delivery_place_de.asp?shownav=1

Field	Format	Data codes	Comments
questionnaire		respondent, or are notified that the woman will not be participating in the survey (mother or baby deceased, moved address, too ill, or called to opt out)	this column should read 17.
Month of receiving questionnaire	N or NN	This is the month you received a returned questionnaire from a respondent, or are notified that the woman will not be participating in the survey (mother or baby deceased, moved address, too ill, or called to opt out)	For example, if the questionnaire was received on May 17th 2010, this column should read 5.
Year of receiving questionnaire	NNNN	This is the year you received a returned questionnaire from a respondent, or are notified that the woman will not be participating in the survey (mother or baby deceased, moved address, too ill, or called to opt out)	For example, if the questionnaire was received on May 17th 2010, this column should read 2010.
Outcome of sending questionnaire	N	1 = Returned useable questionnaire 2 = Returned undelivered by the mail service or patient moved house 3 = Woman or baby died 4 = Woman reported too ill to complete questionnaire, opted out or returned blank questionnaire 5 = Woman was not eligible to fill in questionnaire 6 = Questionnaire not returned (reason not known)	Remember to fill in all the blank cells with 6s when the survey is complete.
Responses to each of the survey questions	N or NN or NNNN		Each column must be clearly headed with the questionnaire question number. Data should be coded using the numbers next to the response boxes on the printed surveys. There is no need to send the women's freetext comments to the Co-ordination Centre.

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

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

Table 3 – Example of data file to be submitted to Acute Co-ordination Centre

Sample Information

Response Information

Record number	Trust Code	Mother's Year of birth	Mother's Ethnic Group	Day of delivery	Month of delivery	Year of delivery	Actual Delivery Place	Place of birth: Trust site code	PCT of Residence	Referring PCT	Day of receiving questionnaire	Month of receiving questionnaire	Year of receiving questionnaire	Outcome	A1	A2_day	A2month	A2_year	A3	A4	G8
1001	RNH	1969	A	1	2	2010	2	RNH15	5LS	5LS	7	5	2010	3							
1002	RNH	1976	C	2	2	2010	0	RNH03	5LT	5LT	13	6	2010	1	1	2	2	2010	3	2	3
1003	RNH	1972	A	2	2	2010	2	RNH15	5T4	5T4	3	7	2010	6							
1004	RNH	1967	A	3	2	2010	0	RNH03	5J3	5J3	4	6	2010	1	2	3	2	2010	4	2	1
1005	RNH	1990	A	3	2	2010	1		5PP	5PP	31	5	2010	1	1	3	2	2010	1	1	1
1006	RNH	1981	D	4	2	2010	0	RNH03	5PP	5PP	12	5	2010	2							
1339	RNH	1978	E	27	2	2010	2	RNH15	5LS	5LS	9	7	2010	6							
1340	RNH	1984	A	28	2	2010	1		5GT	5GT	20	5	2010	1	1	28	2	2010	2	2	1

You should not send any of the womens' written comments to the Co-ordination Centre.

Additional information required

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

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

Delivery

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

Hard copy documents should be posted to the address below.
Postal address:

Maternity Survey 2010
The Co-ordination Centre for NHS Patient Survey Programme
Picker Institute Europe
King's Mead House
Oxpens Road
Oxford
OX1 1RX

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

Deadline for submission

The data and hard copies of documents must be supplied by **20th August 2010**.

17.5 Checklist

Before sending your data to the Co-ordination Centre, carry out the checks listed below, and include this checklist when you submit paper copies of the questionnaire and covering letters. This checklist can be downloaded from the website (www.NHSSurveys.org).

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

If incorrect data are submitted, it is possible that the data will be considered unreliable and will not be used by the Care Quality Commission. We cannot accept re-submissions of data after the deadline, and likewise data is unlikely to then be included in Care Quality Commission assessments.

A printable version of the checklist can be found on our website at:
<http://www.nhssurveys.org/survey/875>

Check	Done?
1) Check that your file name follows the naming convention: <NHStrustName>_Maternity2010.xls)	
2) Check that you have saved the data sheet only as an Excel worksheet , rather than a workbook. (The frequency and percentage counts on the other pages of the workbook on the website are intended for your use only)	
3) Check that you have included data columns for all 77 core questions	
4) Check that you have not included any columns of optional questions	
5) Check that all data are correct , and that all values are in range	
6) If you have increased your sample size beyond the minimum requirement, only send data for the women who consecutively gave birth in your trust in February 2010 (or January and February 2010 if you had to sample back further)	
7) Check that all the data are in numeric format only (except for questions C5 and G8, which may also include text in the next column (i.e. hospital/unit name at C5 and ethnic group at G8)	
8) Check that you have completed the columns for the day, month and year you received the questionnaire back from women	
9) To comply with Data Protection regulations, any women's name and address details must be removed before the file is sent to the Co-ordination Centre	
10) Notify the Co-ordination Centre of the password separately from the data file, either by email or telephone	
11) Include two paper copies of the questionnaire you used	
12) Include two paper copies of the covering letters you used for the first, the second and third mailing.	
13) Include telephone and e-mail contact details of two people who will be available to respond to any queries about the data	
14) Check that you have not included any columns of optional questions	
15) Check again that all data are correct, and that all values are in range	

18 Making sense of the data

Making best use of your survey will depend on how well you plan the process and how effectively you analyse the data. Standard data analysis usually involves examination of the [frequency](#)³² of responses to each question and some [crosstabulation](#) of responses against demographic and other information.

18.1 Using the data entry spreadsheet to look at your results

Once you have entered the data from the core questions into the Excel file on the website (the Data Entry Spreadsheet), the counts and percentages of responses to each of the 77 core questions are automatically calculated and displayed on the other sheets of the Excel workbook. These correspond to sections of the maternity core questionnaire (excluding the "Other Comments" section). For each question, the numbers and percentages of respondents who gave each answer is shown. The number of [missing responses](#) will also be shown, as long as you have coded missing responses on the data sheet as a full stop (.).

18.2 Suggested approaches to data analysis

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

Use the data to help pinpoint problems

It is often tempting to focus on organisational strengths, as this is important for public relations and employee morale. However, if you emphasise only the positive, you may miss a critical opportunity to use the data for improvement. Identifying specific weaknesses provides constructive targets to work towards.

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

"Drill down" into the data

It is impossible to analyse every issue a patient survey raises. A [staged analysis](#) is one way to control the number of analytical questions.

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

Group similar questions together to provide summary analysis

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

³² To review definitions of terms used in this guide, please use the glossary in the appendix. Terms included in the glossary are underlined and in blue font.

- Linking questions that cover similar topics or processes
- Combining several questions into a single composite measure. This can be achieved by averaging response across the set of questions

Use statistical tests to make comparisons and subgroup analyses

Statistical tests can be used to examine relationships and associations between groups. For example, you might wish to look at results broken down by age, sex or ethnic category, to see if different demographic groups are reporting differences in the care they receive. A test of [statistical significance](#) can be used to compare the average results for a given question for different groups to see if differences observed are statistically meaningful rather than due to chance.

If tests show that differences between two groups are statistically significant, this indicates that the different groups you are comparing have reported genuine differences in experience. If the differences between groups are not found to be statistically significant, you should view the patterns of responses as only suggestive.

Please note:

It is essential that any patient survey is conducted in such a way that patient confidentiality is respected and given a high priority. Womens' responses must not be presented to anyone in a way that allows individuals to be identified. It would be unlawful to provide staff who may have had contact with respondents any information that would allow these respondents to be identified. The following recommendations are made:

- 1) The raw data set should not be provided to any member of staff at the trust who does not need to view it, i.e. those who are not directly working on the project
- 2) If data are to be presented to other trust staff, only the aggregated totals for each question should be provided. If analysis by subgroup is carried out, the results for any group consisting of fewer than **30 respondents** should be suppressed (replaced by a dash).

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.

Make use of the open-ended comments

Womens' comments on the back page of the questionnaire can provide valuable feedback on their experiences. Such data illustrate responses to closed questions, and allow respondents to identify new issues not captured elsewhere in the questionnaire. It can be effective to group comments made about similar topics to identify themes in women's experience of maternity care.

Any information that could allow respondents to be identified, such as patient, staff, ward, or unit names should be removed.

Use patient feedback data with other data

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

Perform analysis by sub-groups

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

Table 4 (below) shows the level of confidence you would achieve for various numbers of respondents.

Table 4: Confidence intervals*

Number of respondents	Widest Confidence Interval (+/-) ³³
50	13.9%
100	9.8%
200	6.9%
300	5.7%
400	4.9%
500	4.4%
600	4.0%

*at a 95% confidence level

If you are interested in looking at different sub-groups within your trust population (for example, women who gave birth at different maternity units in your trust), you will need to think about the number of respondents you need in each group, and how this will impact on the confidence you can have in the results. The Co-ordination Centre recommends a minimum of 100 respondents per group for comparison between sub-groups. Confidence intervals for analysis with groups of fewer than 100 respondents will be so large that there would be little certainty of detecting reliable statistical differences³⁴

Example

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

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

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

³³ This column (the widest confidence interval) shows the maximum margin of error for binomial estimates of proportions

³⁴ A **confidence interval** is an upper and lower limit within which you have a stated level of confidence that the trust mean (average) lies somewhere in that range. The width of the confidence interval gives some indication of how cautious we should be; a very wide interval may indicate that more data should be collected before any conclusions are made.

19 Reporting results

NOTE:

Trust-level findings for the national maternity survey 2010 should not be released outside of the trust until the national results are published by the Care Quality Commission. Please continue to use the results from your in-house survey teams or approved contractor to improve services, but wait until the survey results for all trusts are published by the Care Quality Commission before promoting your results in any way (either on your website, in press releases or any other external publicity) to the local community and media. You will receive, along with communications staff in your trust, advance notice of the publication date and will have time to prepare for your local announcements once the embargo is lifted.

19.1 Prioritising your findings

Patient surveys can raise many important issues. To make sure that the data is used, the results must be presented clearly and logically. To help you with this task, you may like to consider the following suggestions:

Rank results by their magnitude

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

Examine performance along themes or aspects of the maternity care pathway

If women report more problems with certain aspects of their maternity care pathway, it may be appropriate to pay extra attention to these areas (e.g. tests and scans). Dividing your results into themes for analysis (eg: information during pregnancy, tests, support with feeding) can also help identify organisational strengths and weaknesses

Compare results within your organisation

Comparisons within organisations can facilitate the sharing of information about effective practices among units or departments. If survey results show that a number of departments at your trust have problems in a certain area, they may be able to work together on improvement efforts. Initiatives are likely to be more effective when a number of staff are working on them, and internal 'competitiveness' may also encourage improvement efforts. As noted in Section 1.2, if analysis by subgroup is carried out (e.g. comparing results between departments), the results for any group consisting of fewer than **30 respondents** should not be shown.

Compare results over time

Investigating [trends](#) in survey results over time is a powerful analytical tool for prioritising areas for improvement. Analysis of trends allows you to focus on addressing aspects of performance that are deteriorating, and promoting those that are showing progress. You should confirm that any apparent changes between years are statistically significant. The nature of a trend in the data (does the trend go up, or down, or is there no trend) and the extent of any trends or changes (are they steady, sharp rises or falls, or erratic) are good starting points for making comparisons over time. It should also be possible to measure the impact of any initiatives that have been introduced.

However, the composition of both the samples and the respondents can vary significantly between surveys, even if the sampling criteria remain unchanged. Certain groups of women respond more positively than others, such as multiparous women when compared with primiparous women; if your results improve significantly from one survey to the next but the proportion of multiparous women has increased, the improvement may be due to a change in those responding. One solution to this issue is to "standardise" your data, ie to control for these variations in population so

that you can be more confident that any change reported is due to changes in service quality, not just those who are responding.

If comparing two or more sets of survey results, we suggest that you compare the key demographics of the respondents early in your analysis. If there are significant differences in the proportions of respondents by maternal age, ethnic group or parity, you may need to weight, or otherwise standardise, your data. Some analysis programmes can standardise your data for you but you may need to seek the assistance of a statistical expert before you attempt to control for variations in respondent demographics.

Compare your results against national findings

A common method of prioritising your findings is to select issues that show differences to the national survey results. Identifying areas where your trust compares unfavourably with national results allows you to focus on areas of comparative weakness, while areas where your trust performed better than the national average can be encouraging to staff. Your trust's results can be compared with those from the most recent national survey that was undertaken as part of the patient survey programme. The national results from previous surveys are located on the Care Quality Commission's website (www.cqc.org.uk/patientsurveys)

Comparison with predefined goals

Setting threshold or target goals prior to the survey will help you focus on issues where performance does not meet them. This method is particularly effective when there is clear consensus on what those targets should be, for example on questions about choice of birth place and provision of antenatal screening. It can also be used to evaluate internal targets or elements of care that the trust is focusing on.

Correlation with overall measures

Correlating womens' responses to specific questions with responses to the questions about overall quality of care during a) pregnancy, b) labour and birth and c) after the birth can help focus attention on issues that are important for women. These issues can then be given priority in your trust's quality improvement work.

Predictive value on overall measures (regression analysis)

Similar to correlation, [regression analysis](#) also gives a sense of the issues that have most impact on womens' overall assessments of care. Regression analysis is superior to simple [correlation](#). It can adjust for other factors 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. For example, demographic information such as age and parity can be controlled for in analysis so that a clearer picture of the relationship between items can be determined. Regression analysis is more complex than simple correlation but it allows for a more meaningful comparison.

Ease of action

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

Areas of excellence

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

Summarise your data

Translating the large quantity of data you collect into accessible information is vital for informing staff. Too much data will be overwhelming and make it difficult to identify key issues.

Summarising your data will also help management make important decisions in response to the survey.

Don't overlook insignificant results

If there are areas that have shown little or no change from previous years, this suggests that additional work is needed for improvements to occur. This is often true of areas where making changes poses a significant challenge, and where attention to quality improvement is particularly important.

19.2 Writing the report

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

Tailor the document to the audience

- Use brief, succinct summaries for executive audiences.
- Include anonymised quotes from the women's freetext comments to illustrate data and figures
- Produce comprehensive summaries for those who will implement improvements. They will help achieve buy-in and generate action
- A separate resource booklet or data disks/CD-ROMs with full details may be important if staff or researchers have questions.
- Don't forget to acknowledge women and thank them for their participation in the survey

Use graphics

- Data that are displayed visually can be easier to interpret.
- Display trends or comparisons using graphics such as:
 - **bar charts** – these are easy to read and can be used for effective comparison between questions and to show year on year changes
 - **pie charts** – these are useful for describing proportions that make up the whole, for example, the proportion of patients who were and were not given a choice of admission or appointment date
 - **line charts** – these are effective at showing trends over time

Some tips for using graphics:

- Remember that colours don't photocopy or fax very well. For bar charts, try using different patterns instead
- Give each graph a clear title detailing which question(s) are being reported
- Make sure the categories or values of the variable are clearly identified
- Don't include too many graphics. Select those results that can be well illustrated using graphs or charts
- Using a consistent format throughout helps understanding
- Pie charts are more informative when there are a small number of categories

Keep the format succinct and consistent

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

Emphasise priorities clearly

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

20 Using results for quality improvement

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

20.1 Prepare in advance

To ensure that the survey will result in improvements, plan for improvement work before the survey is conducted.

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

20.2 Dissemination of survey results

Engage key stakeholders

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

- Frontline staff throughout the trust (including volunteers) as they will be responsible for tackling any problems identified by women
- Local commissioners who purchase your services
- Board members as they are involved in prioritising areas for improvement and shaping action plans. Senior level support is often crucial for the successful implementation of change
- Recent mothers have taken time to report their experiences so it is important they are informed of the results via local meetings, newsletters and articles in the local press
- Patient groups with special interest in the trust who may have a key role to play in initiating discussions with the board about priorities for improvement and be keen to monitor progress as it occurs
- Other local healthcare organisations as they may be tackling similar issues
- Your communications department, as they can help publicise the survey and its findings
- When reporting the results invite people to contribute their ideas on how services could be improved and to suggest ways in which they can become involved.

Spread the Word

Disseminating survey results is more than just producing and photocopying a report. Consider how to share the survey results in a number of situations, for example:

- training sessions – you may wish to focus on a few specific topics to concentrate on
 - staff and public meetings – this can inform patients and staff, and publicising findings commits the trust to improvement initiatives
 - employee newsletters – this provides the opportunity for all staff to receive feedback
 - executive communications
 - process improvement teams
-

- patient care conferences
- information available on your website

When considering the best way to share your survey results, you should bear in mind the audience you are working with. You may wish to consider the following:

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

20.3 Identify key staff

The people who can motivate others to bring about change and who hold the 'keys' to improvement in the organisation are not always the most senior members of staff. Identify these individuals and involve them as early in the survey process. Brief them on the survey's findings and request feedback about their success from these individuals.

20.4 Develop an action plan

Having used your survey results to identify areas for improvement, we recommend you work with staff and patients/women to prioritise the work needed, and then identify the actions required. Initially it is a good idea to focus on one or two key areas for improvement and not to attempt to tackle all of the issues at once. Set your goals and objectives and then divide tasks into manageable steps and achievable targets. Choose areas that show clear potential for improvement. If plans are too ambitious they may fail so it is important to be realistic and choose approaches that are likely to succeed. Small successes will help keep the momentum going and encourage continuous improvement. Focusing on issues that present solutions – for example, improving information provided to women about where they can give birth to their baby – and choosing topics currently being considered by existing groups in your trust will help to gain the ownership and involvement of staff and patients and avoid duplication of effort.

Work out realistic timescales for reaching your goals as well as details of how and when progress will be measured. Identify the individuals who will be responsible for taking this work forward. This will form the basis of an action plan which can be updated on a regular basis. An action plan template is included in the Picker Institute's guide to using patient feedback (see www.pickereurope.org/usingpatientfeedback).

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

- Patient Advice and Liaison Service (PALS)
- Complaints
- Service Improvement/Modernisation teams
- Patient and Public Involvement (PPI) team
- Patient Panels

Publishing regular progress reports widely throughout your trust and the local area will help to enlist ongoing support. Repeat surveys can then be used to monitor improvements.

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

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

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

Trust type: **Acute and specialist**

Survey: **Women's experiences of maternity care**

Example titles: [What do women think about our maternity services?](#)

[National maternity survey](#)

[Understanding women's experiences of maternity services](#)

[Women's views vital to drive service improvements in maternity care](#)

[NHS Trust name / Hospital name] are carrying out a survey to find out what women think about their maternity care. Every NHS hospital trust in England that provides maternity care is carrying out this survey as part of the national patient survey programme led by the Care Quality Commission.

Why are we doing another patient survey?

A maternity survey was carried out as part of the national patient survey programme in 2007. We are carrying out another survey, using a similar questionnaire and methodology, to [track any changes in women's experiences over time so we can continue to improve services / or to evaluate the success of quality improvement initiatives implemented since the last survey](#) Obtaining feedback from women and taking account of their views and priorities is vital for bringing about improvements in the quality of care.

When is the survey taking place?

Questionnaires will be posted to women during April and May. Up to two reminders will be sent to those who have not responded between May and July.

Women are being asked about various aspects of their care, including check-ups during pregnancy, tests and scans, care during labour and birth, communication with health professionals, care in hospital after the birth, feeding the baby, and care at home after the birth.

Who is the survey being sent to?

The survey will be sent to [number] women, aged 16 years and over, who gave birth during {January and} February 2010. [\[If a survey contractor is being used: An external survey contractor, {name}, is administering the survey so that women's responses are anonymous\] \[If carrying out the survey in-house: Women's responses will be treated in confidence and their name and address will never be linked to their response.\]](#)

How have the results from previous survey been used?

Results from the 2007 maternity survey helped to identify areas where there was most room for improvement [\[a summary of the key findings from the previous survey and how the trust acted on the results can be inserted here\]](#)

When will the results of this survey be available?

The results of this survey will be used by the Care Quality Commission as part of their regulatory activities. In addition to providing a national overview, the Care Quality Commission will publish data from the survey to allow trusts to make meaningful comparisons between themselves based on reliable data. The results will be published in the autumn on the Care Quality Commission's website: <http://www.cqc.org.uk>

Where can I find out more?

For more information about the survey, please contact [\[lead survey name and contact details\]](#)

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

Title: [\[NHS Trust name\] seeks women's views or](#)

[Women's views vital to drive service improvements](#)

[Your chance to tell \[NHS Trust name\] about the quality of maternity care](#)

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

Women who had a baby at [Hospital/unit A and Hospital/unit B / and at home] during {January and} February may receive a questionnaire by post in April/May, asking about their experiences. They will be asked about various aspects of their care, including check-ups during pregnancy, tests and scans, care during labour and birth, communication with health professionals, care in hospital after the birth, infant feeding, and care at home after the birth.

[NHS Trust name] believes that taking account of women's views and priorities is vital for bringing about improvements in the quality of care. Results from the survey will be used to *[insert purpose of survey here, e.g. to track women's experiences of maternity care since the last survey was undertaken in [2007] / or to measure the impact of changes made to improve maternity services based on feedback from the 2007 survey / or to find out if recent changes made to the service has led to an improvement in women's experiences]*

Every NHS hospital trust in England that provides maternity services is carrying out this survey as part of a national programme led by the Care Quality Commission. This survey is part of the commitment, set out in the *NHS Plan*, to design a health service around the needs of patients.

Results from the previous 2007 maternity survey helped to identify areas where there was most room for improvement *[a summary of the key findings from the previous survey and how the trust acted on the results can be inserted here]*

To ensure confidentiality, the results of the survey will be presented in a form that does not allow any individual's answers to be identified. The results will be published in the autumn on the Care Quality Commission's website: <http://www.cqc.org.uk>

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

Appendix 3: Glossary

Confidence interval

A confidence interval is an upper and lower limit within which you have a stated level of confidence that the true mean (average) lies somewhere in that range. These are commonly quoted as 95% confidence intervals, which are constructed so that you can be 95% certain that the true mean lies between these limits. The width of the confidence interval gives some indication of how cautious we should be; a very wide interval may indicate that more data should be collected before any conclusions are made.

Correlation

The extent to which two or more variables are related to one another. This is expressed as a 'correlation coefficient', which can range from 0 to 1, which indicates the strength and direction of a relationship between two variables. However, correlations do not necessarily indicate a causal relationship of two variables: we can know that they are related but one might not be causing the other.

Crosstabulation

Crosstabulations (also known as crosstabs) are used to present data about two variables in a table, which makes their relations more obvious. A crosstab table displays frequencies classified according to another variable (for example, overall ratings of antenatal care by age) which makes it easier to see the differences in ratings of data about antenatal care between different age groups.

Frequency

The number of times a particular response is given. For example, if 132 women who responded to your survey said that they had been given information about the NHS Choices website, and 24 respondents said that they were not given this information, the frequencies of these findings are 132 and 24, respectively. The data entry spreadsheet automatically displays the frequencies for each response option.

Missing responses

Information not available for a respondent – for example, when they fail to answer one of the survey questions that they should have answered. Data is not considered missing if the filter instructions on a questionnaire instruct the women not to answer certain questions.

Population

A group of people that you want to make generalizations about, e.g. all patients who have attended A&E, all women who have recently had a baby, all patients that have had an inpatient stay or outpatient appointment.

Regression analysis

A method of estimating the variability of a dependent variable by using information about one or more independent variables. Regression analysis aims to predict values of the dependent variable, given certain values of the independent variables. Because of its predictive power, regression analysis is more powerful than correlational analysis as we can assume a causal relationship between variables.

Sample

Because it is not practical to study an entire population (because the numbers would be too high), we select a group of people from the population – called a sample – that is expected to be representative of the population. The process of collecting information from a sample is referred to as sampling.

Staged analysis

This involves analysing the data in progressive depth to identify both broad measures of overall performance and more detailed patterns in the findings.

Statistical significance

The degree to which a result is substantially different than would be expected by chance alone. For example, if the difference in data for a question from two survey years is statistically significant, this means that there has been a true change in the results that cannot be attributed solely to chance.

Summary analysis

Presenting the data from more than one question as one overall score to provide a total measure of an element of care. This involves calculating a mean response for the set of questions that you are interested in.

Trend

The movement in one direction of results to a particular question over a period of time. For example, if patients have reported progressively higher levels of cleanliness over a number of survey years, we can say that there is a trend of improved ratings of cleanliness.