



## **NHS Patient Survey Programme**

# **2018 Adult Inpatient Survey: Quality and Methodology Report**

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# Introduction

This report provides detailed information on key quality and methodological issues relating to the 2018 Adult Inpatient Survey. It covers the development, implementation and analysis of the survey, as well as the quality of the data and any points that should be noted when using the outputs. More detail on the development of the survey and errors made during the sampling process can also be found here: <http://www.nhssurveys.org/surveys/1203>.

The Adult Inpatient Survey is the longest running survey in the NHS Patient Survey Programme (NPSP). The Survey Coordination Centre, based at Picker, manages and coordinates the programme at national level, on behalf of the Care Quality Commission (CQC).

The survey is run on an annual basis, with all NHS acute hospital trusts in England participating. The 2018 survey is the sixteenth iteration since the inception of the NPSP in 2002, and was concerned with inpatients who were discharged from an NHS England trust during July 2018. Each trust selected a sample of 1,250 patients, by including every consecutive discharge counting back from 31st July 2018; with a minority of smaller trusts sampling as far back as January 2018<sup>1</sup>, as required. In total, 144 NHS England acute specialist trusts partook in the survey, with 76,668 questionnaires being successfully completed by patients; an adjusted response rate of 45%.

An overview of our approach to quality within the NHS Patient Survey Programme (NPSP) is available in the 'NHS Patient Survey Programme: Quality Statement' document, available here: [cqc.org.uk/sites/default/files/20151125\\_nhspatientsurveys\\_quality\\_statement.pdf](http://cqc.org.uk/sites/default/files/20151125_nhspatientsurveys_quality_statement.pdf)

## Survey development

### Survey design and implementation

The NPSP is committed to best practice for all stages of the survey, including the processes taken to improve the methodology. From extensive desk research, consultation with stakeholders and pilot work, a number of measures have been implemented to help maximise response rates, including:

- Development of survey questions that are relevant to all, or most, people in the sample.
- Questionnaires written using simple and clear language.
- Use of cognitive interviewing to test questions and response options with people who have recently used NHS services, in order to ensure that they are easily understood and relevant.
- Reassurances of anonymity and confidentiality in all written communications
- Sending up to two reminders to non-responders.
- Long fieldwork periods to encourage lesser-heard groups, such as minority ethnic groups, to respond<sup>2</sup>.
- A Freephone language line providing translation services.
- Contact details for Mencap which offers support for people with learning difficulties.

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<sup>1</sup> Three specialist trusts had to sample back to January 2018: The Clatterbridge Cancer Centre NHS Foundation Trust (REN), Liverpool Women's NHS Foundation Trust (REP) and Birmingham Women's and Children's NHS Foundation Trust

<sup>2</sup> For more information, please see [http://www.nhssurveys.org/Filestore/documents/Extension\\_of\\_fieldwork\\_for\\_inpatient\\_survey\\_2007.pdf](http://www.nhssurveys.org/Filestore/documents/Extension_of_fieldwork_for_inpatient_survey_2007.pdf)

- Use of a Quality Assurance Framework ensuring all survey materials and results are reliable and accurate.

Like all other surveys in the NPSP, the Adult Inpatient Survey uses a postal survey mode whereby questionnaires are sent to patients' home addresses. This aims to reduce the effects of social desirability bias, which can arise when people give feedback either directly to staff, or while on trust premises.

A number of steps were taken to ensure the quality of the survey design and implementation. As with all surveys in the programme, an external advisory group is consulted to ensure that a range of internal and external stakeholders are given the opportunity to provide input during survey development. The advisory group included representatives from CQC, NHS England, Patient Representatives, NHS trust representatives and the Department of Health and Social Care. Questionnaires were also cognitively tested with patients, as described in the '[Questionnaire development](#)' section below.

There were two minor and one major changes made to the survey methodology in 2018:

- Minor changes were made to all three mailing letters in order to make them more engaging, empowering, concise and tailored, with the aim of increasing response rates. Another minor change was in regard to the dissent posters; for the first time this year the dissent posters were published in the 10 most commonly spoken languages in England (including English).
- The major change in the survey methodology was the timing between the first and second (first reminder) mailings; where this was previously 2 weeks, it was reduced to 5 days following a successful pilot that ran alongside Inpatient 2017, which demonstrated this had a significant effect on response rates.

Further information about these methodological changes can be found in the survey development report: <http://www.nhssurveys.org/survey/2117>.

All surveys follow a strict methodology, as specified in the [survey handbook](#), which all in-house trusts<sup>3</sup> and approved contractors<sup>4</sup> must follow. Any deviation from the survey instructions, depending on severity, may result in data being excluded from published results. Any decision to exclude data is made by the Surveys Team at CQC in conjunction with the Survey Coordination Centre, based on discussion with and evidence provided by, the trust(s). One trust was excluded from the 2018 Adult Inpatient publication.

## Questionnaire development

Following consultations with key stakeholders and analysis of the 2017 survey results, one question was removed, two new questions added and one item modified.

Prior to fieldwork, this redeveloped questionnaire was cognitively tested with 18 volunteers who had stayed in hospital for one or more nights in the previous six months. Respondents completed a questionnaire with a researcher to check that the questions and response options were appropriate and were understood as intended. The testing took place across five different locations (Oxford,

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<sup>3</sup> These are trusts who have opted to carry out the survey themselves.

<sup>4</sup> These are companies that have been approved by the CQC during a competitive tendering process to carry out surveys in the NPSP on behalf of trusts. For more information please see: [nhssurveys.org/approvedcontractors](http://nhssurveys.org/approvedcontractors).

Birmingham, Bicester, London and Banbury). Attempts were made to include volunteers of mixed ages and ethnic groups however there was only one non-White volunteer and the youngest volunteer was 35. Interviews were carried out in three rounds, with alterations made to certain questions between rounds in accordance with feedback from participants and stakeholders.

For more information about the cognitive testing process and amendments made to the 2018 questionnaire please see section 3 of the survey development report at:

<http://www.nhssurveys.org/survey/2117>.

See the questionnaire of the 2018 Adult Inpatient Survey provided in Appendix A.

## Sampling and fieldwork

### Sampling

All trusts that provide adult inpatient services were eligible to take part in the survey. In total, 144 acute specialist trusts participated in the 2018 survey.

Patients were eligible for the survey had they spent at least one night in hospital and had been discharged during July 2018, and were aged 16 years and over. Trusts with fewer than 1250 eligible discharges in July were required to sample backwards into earlier months (working backwards from 31<sup>st</sup> July) to reach the required sample size. Despite sampling back to January 2018, three specialist acute trusts were unable to reach the required 1250 sample size but had sufficient numbers of patients over the sampling period to be included (the smallest sample received was 717 from Birmingham Women's and Children's NHS Foundation Trust). Trusts were required to compile their sample according to strict eligibility criteria excluding the following groups as follows:

- Deceased patients
- Children or young persons under 16 years old at the time of sampling
- Obstetrics/maternity service users, including spontaneous miscarriages.
- Patients admitted for planned termination of pregnancy.
- Psychiatry patients.
- Day case patients; those patients who arrived and left on the same day.
- Private patients (non-NHS).
- NHS patients treated at private hospitals.
- Any patients who are known to be current inpatients at the time of sampling.
- Patients without a UK postal address or patients whose address was unuseable because incomplete.
- Any patient known to have requested their details are not used for any purpose other than their clinical care.

Fieldwork for the survey (the time during which questionnaires were sent out and returned) took place between August 2018 and January 2019. However, the length of fieldwork varied from one trust to another. As fieldwork can only start when the trust individual sample has been approved, some trusts whose sample approval was delayed had shorter fieldwork period. Across all participating trusts, the fieldwork length varied from 5 to 19 weeks (the average fieldwork length was 14 weeks). Further information about the sampling process is available in the sampling handbook here: <http://www.nhssurveys.org/survey/2148>.

## Sampling error

The sample size for the Adult Inpatient Survey was 1250 discharged patients per trust; of which there are 144. Assuming the sample period is not atypical, the large sample size for the 2018 survey sample can be considered representative of all eligible inpatients in England. The sampling period was a typical July month suggesting that the provision of NHS inpatient services in July 2018 is comparable to previous survey results. However, if an inpatient survey were to have a different sampling month, for instance a month during winter, results may differ due to seasonal effects.

## Trust mergers

The results for England are based on an average of the pooled results from all participating trusts. Changes in the number of participating trusts have a very small effect on the results for England. However, when reporting individual trust results it would be inaccurate to display historical data if a trust has undergone a merger since the previous survey.

There were four trust mergers since the 2017 survey:

1. University Hospitals Birmingham NHS Foundation Trust (RRK) formed from a merger between Heart of England NHS Foundation Trust (RR1) and University Hospitals Birmingham (RRK)
2. Manchester University NHS Foundation Trust (R0A) formed from a merger between University Hospital of South Manchester Foundation Trust (RM2) and Central Manchester University Hospitals NHS Foundation Trust (RW3).
3. Colchester Hospital University NHS Foundation Trust (RDE) and Ipswich Hospital NHS Trust (RGQ) merged to form East Suffolk and North Essex NHS Foundation Trust (RDE).
4. Burton Hospitals NHS Foundation Trust (RJF) and Derby Teaching Hospitals (RTG) have also merged to form University Hospitals of Derby and Burton (RTG)

The three newly merged trusts of University Hospitals Birmingham NHS Foundation Trust, Manchester University NHS Foundation Trust and East Suffolk and North Essex NHS Foundation Trust did not receive historical comparisons in 2018. The University Hospitals of Derby and Burton will be presented as two separate trusts (i.e. Burton Hospitals NHS Foundation Trust and Derby Teaching Hospitals) in the 2018 reporting due to contractual commitments and system configurations.

## Errors in drawing samples

The chances of sampling mistakes being made by trusts (for example, excluding certain eligible patients) are minimised by multi-stage sample checks. Firstly, trusts are provided with a checklist to review their sample. Trusts that appoint a contractor to undertake the survey on their behalf will then have their sample reviewed by their contractor. Finally, all anonymised samples are checked by the Survey Coordination Centre which looks for errors that are more noticeable when pooling data together, such as unusual or skewed age distributions.

During the Survey Coordination Centre's sample checking process, several items are checked against the previous years' submissions to help ascertain whether a trust has followed the guidelines correctly. These include comparisons of age, gender, and ethnicity, route of admission,

discharge dates, length of stay, ICD-10 chapter codes, CCG's, Treatment Function Codes and admission method codes. If there are any concerning discrepancies, queries will be raised with the contractor or in-house trust as appropriate.

Errors identified from these checks are classified as either minor or major. A minor error is defined as a mistake that will not affect the usage or quality of the survey response data. One example of a minor error is applying patient record numbers in an incorrect format. Minor errors can be rectified by the trust, contractor or Survey Coordination Centre as appropriate, without the need for the sample to be redrawn or patients to be added or replaced.

A major error is defined as an error that will affect the usage or quality of the response data. An example of this type of error is exclusion of a particular hospital site or patients with a particular route of admission to hospital, which potentially creates bias in the sample. If a major error is spotted during sample checking, the trust is required to totally redraw their sample or add/remove patients as appropriate.

A sampling errors report is produced each year and is published on the NHS Surveys website. Trusts and contractors are encouraged to review this report to minimise the recurrence of previously detected errors. As detailed in the 2018 report there were 17 major errors and 33 minor errors identified in samples submitted to the Survey Coordination Centre for the 2018 Adult Inpatient Survey (see <http://www.nhssurveys.org/survey/2338>).

A sample declaration form, which trusts must complete prior to submitting their sample, is used to help further reduce sampling errors. This form outlines a number of required checks to ensure that the sampling instructions have been followed. It also helps to confirm that trusts have maintained patient confidentiality by taking the steps laid out in the instruction manual, such as only sharing the required variables. Approval of this form by the trust's Caldicott Guardian prior to data submission not only fulfils the trust's requirements under the Data Protection Act, but also reduces the potential for breaches to the support received under Section 251 of the NHS Act 2006.

We have explored the way in which trusts input data for patients before it is used to create survey samples, in order to identify the level of risk for error at that stage. This is outlined in the Statement of Administrative Sources, available on the CQC website [here](#). It was concluded that, although the potential does exist for inaccurate addresses or coding of cases at this stage, this is unlikely to occur due to the data quality requirements placed upon NHS trusts. As a result, the chances of such errors occurring at this stage are small enough that any impact on trust results is likely to be minimal, and in turn, would have an even smaller impact on the aggregated results for England.

## Historical sampling errors and historical comparisons

Part of the Survey Coordination Centre's sample checking process involves comparing a trust's sample data to their samples from previous iterations of the survey and investigating any discrepancies. This can sometimes reveal errors in samples from previous years, which only become apparent when comparing with the current year's sample<sup>5</sup>. If these are classified as major

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<sup>5</sup> Whilst the Survey Coordination Centre undertakes robust checks on the sample, it is not always possible to identify all sampling errors from the sample declaration form and anonymised sample file. Therefore some errors are identified retrospectively when checking the current year's data. It remains the responsibility of trusts to ensure samples are drawn correctly and that all inclusion and exclusion criteria have been correctly applied.

errors, historical comparisons between the current and previous years may not be possible for the trust in question.

The Survey Coordination Centre checked each trust's 2018 sample against their 2017 and 2016 sample. A number of investigations were undertaken to understand where possible sampling errors had occurred in previous survey years. As a result, two trusts were excluded from being provided a historical comparison:

R1H – Barts Health NHS Trust

RRV – University College London Hospitals NHS Foundation Trust

For more information about the historical errors and trusts with service changes identified during the 2018 survey please see the sampling errors report at <http://www.nhssurveys.org/survey/2338>.

In addition to the above, four trusts had major service changes and/or acquisitions. Although these trusts did not make a historical error, investigations concluded that historical comparisons were not appropriate to make:

REN – The Clatterbridge Cancer Centre

RDD – Basildon and Thurrock University Hospitals

RGN – North West Anglia

RAE – Bradford Teaching Hospitals

Several trusts were late entering fieldwork due to delays in the sampling process. Seven trusts were delayed leading to only 5-6 weeks of fieldwork. Demographic differences in response patterns can result from a short fieldwork period which can impact the quality of the data and comparability between and within trusts. For six of these trusts, conclusions were made that although the responses were generally comparable to their historic data, a few specific areas differed, making it inappropriate to provide historical comparisons:

RE9 – South Tyneside NHS Foundation Trust

RJ6 – Croydon Health Services NHS Trust

RJE – University Hospitals of North Midlands NHS Trust

RRK – University Hospitals Birmingham NHS Foundation Trust

RT3 – Royal Brompton & Harefield NHS foundation Trust

RXN – Lancashire Teaching Hospitals NHS Foundation Trust

RET – The Walton Centre NHS Foundation Trust was late-in-field and also had additional errors with their mailings resulting in a large proportion of their sample not receiving a mailing. The investigation for this trust resulted in excluding them from the 2018 survey results.

## Fieldwork

Fieldwork for the 2018 Inpatient Survey took place between August 2018 and January 2019, with an average of 14 weeks of fieldwork for trusts. Every week during fieldwork, approved contractors and in-house trusts sent the Survey Coordination Centre a weekly monitoring report, summarising the outcome status by use of the following codes:

Outcome 1 = questionnaire returned completed



Outcome 2 = questionnaire returned undelivered  
Outcome 3 = patient deceased after the start of fieldwork  
Outcome 4 = patient too ill or opted out  
Outcome 5 = patient ineligible for participation (i.e. under 16, never an inpatient etc.)  
Outcome 6 = no response from patient  
Outcome 7 = patient deceased before the start of fieldwork

From the above outcome codes, the adjusted response rate was calculated by dividing all patients that returned a completed questionnaire (Outcome 1) by all patients that potentially received the questionnaire and were potentially able to respond:

$$\text{Adjusted response rate} = \frac{\text{outcome 1}}{\sum(\text{outcome 1, 4, 5 and 6})}$$

The weekly monitoring allowed the Survey Coordination Centre to track the progress of the survey throughout fieldwork and enable them to identify and assist with any potential problems at any stage.

## Data analysis and reporting

### Data cleaning and editing

Survey data from each participating trust - whether conducting the survey in-house or via a contractor<sup>6</sup> - are submitted to the Survey Coordination Centre for cleaning. During fieldwork, a data cleaning manual that the Survey Coordination Centre undertakes is published (see <http://www.nhssurveys.org/survey/2279>). This document allows in-house trusts and contractors to understand and replicate the Survey Coordination Centre's cleaning processes. However, trusts and contractors are required to only submit raw data (i.e. uncleaned data) to the Survey Coordination Centre at fieldwork close. Data is submitted to the Survey Coordination Centre in an Excel file, although the final dataset for the survey is an SPSS file. A version of this data is available for secondary data users at the UK Data Service (UKDS).

There are a number of standard checks undertaken on the data. These include checking that:

- Hardcopies of the questionnaires from contractors and in-house trusts are correct i.e. questions, response options, routing and instructions as they should be.
- The number of rows of data (i.e. the number of patients) is as expected.
- The variable, question and response option wording matches the questionnaire.
- There are no out-of-range values in either sample or response data.
- Routing has been followed correctly (i.e. respondents have not answered a question that does not apply to them).
- All response coding falls within the expected range of response options for a question.
- Response data reflects the sample data (e.g. year of birth in the sample data matches the year of birth reported by the respondent).
- Only eligible patients were included in the survey.

The data is also checked for a number of other, more in-depth, errors. This includes looking at questionnaire item non-response, which can indicate if a question is not necessarily being

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<sup>6</sup> In 2018 all but seven participating trusts chose to use a contractor.

understood in the way it has been designed. In addition, high levels of missing data on suites of questions that are positioned next to each other can indicate an issue with page turnover.

When data is suppressed for a question, which occurs when there are fewer than 30 responses for a trust, this is cross-referenced against the raw Excel data submitted by a trust to confirm that the suppression was correctly applied. When a trust has a low response rate, the data is also checked against the sample for representativeness (in terms of demographics), in order to determine whether the data should be included. As mentioned previously, there was one exclusion made from the 2018 data due to representativeness concerns.

When errors are found, in-house trusts or contractors are asked to correct their data and resubmit. One contractor resubmitted following the realisation that they had delivered data where Q78 (year of birth) was already cleaned instead of the raw, uncleaned data.

## Statistical release

A statistical release has been published which provides full England-level results for the 2018 survey compared against previous survey years, and a multi-level analysis of subgroups. This is published on the CQC website here: <http://www.cqc.org.uk/surveys/inpatient>.

The data is weighted in order to control for the influence individual trusts' response rates have on the England-level average<sup>7</sup>. For questions that are comparable across survey years, comparisons were made using Z-tests to determine whether differences between 2017 and 2018 are statistically significant. Control charts displaying trend data have also been produced for each question evaluating care where more than 5 years consecutive data points were available. The chart is a 'p-chart' and these plot the percentage of the most positive responses to a question (top box) and show the 'expected limits' of variation in survey results under the hypothesis is that there has been no change in reality. The upper and lower limits show the boundaries outside of which year-on-year change is considered 'notable', meaning that the degree of change is greater than the standard variation you would expect to see around results year-on-year given that there has been no underlying change. When changes fall outside of the expected limits, it suggests an underlying phenomenon at play or there has been a change in behaviour. However, an isolated point outside the limits may not indicate any underlying shift.

The multi-level analysis of subgroups highlights the experiences of different demographic sub-populations. Results for each demographic subgroup were generated as adjusted means (also known as estimated marginal means or population marginal means) using a linear mixed effects model. These means were compared within themes, derived from composites of results from specific questions. This model takes into account trust-level effects, as trusts are likely to have an effect on reported patient experience at an England-level. Predictor variables were checked for multicollinearity to ensure coefficients could be accurately estimated. Differences of at least 0.1 standard deviations from the overall mean of the target variable, and with 95% confidence intervals that do not include the grand mean, are treated as being noteworthy.

For the 2018 survey the following demographic subgroups were analysed:

- Age group
- Ethnicity

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<sup>7</sup> More information on the weighting approach applied to the data can be found in the '[Addressing potential non-response bias in the survey results](#)' section of this report.

- Gender
- Religion
- Sexual orientation
- Long-term health conditions
- ICD-10 Chapter Code
- Route of Admission (Emergency or elective)
- Length of stay
- Case Type (Medical or surgical)
- Respondent (in person or by different proxy)

We compared the experience of different groups across a number of themes:

Information, communication and education: Q30 Q36 Q56 Q63

Respect for patient-centred values, preferences and expressed needs: Q23 Q26 Q34 Q39 Q48

Emotional support: Q37 Q38

Confidence and Trust: Q24, Q27, Q35

Coordination and integration of care: Q32 Q54 Q61 Q65

Food Choice: Q20

Hydration: Q22

Respect and Dignity: Q67

## Trust results

Analysis is conducted on the data at trust level to allow comparisons to be drawn between the performances of different trusts for individual questions in the survey. The method for this analysis is detailed in the technical document here: <http://www.cqc.org.uk/surveys/inpatient>. The results of this analysis are published in benchmark reports for each individual trust, available here: <http://www.nhssurveys.org/surveys/1426>. We also produce a benchmark report which covers all sections of the questionnaire.

For questions of evaluative nature, each response option is assigned a score (from 0-10), and composite section scores are then produced by grouping similar questions together. Demographic questions, non-specific responses, some routing questions and other questions that do not evaluate a trust's performance are not scored. A scored version of the questionnaire can be found here: <http://www.nhssurveys.org/survey/2230>.

In the benchmark reports for each trust, their question score is calculated by taking the weighted average<sup>8</sup> of responses for the trust, for the given question. A chart is produced for each scored question and each section of the questionnaire, unless a question has fewer than 30 responses<sup>9</sup>. These charts show the overall range of trusts' scores for a question, broken down into three parts (where a black diamond indicates the score of the trust in question):

- If the black diamond lies in the orange section of the graph, the trust result is 'worse' than expected when compared with most other trusts in the survey.

<sup>8</sup> Weighting the responses adjusts for variation between trusts in age, gender and type of admission

<sup>9</sup> If a question has fewer than 30 responses for a given trust, the confidence interval around the trust's question score is considered too large to be meaningful and results are not reported. Additionally, for any such question, the trust is excluded from England averages and is not given a section score.

- If the black diamond lies in the green section of the graph, the trust result is 'better' than expected when compared with most other trusts in the survey.
- If the black diamond lies in the grey section of the graph, the trust result is 'about the same' when compared with most other trusts in the survey.

An example of a chart is shown below:



Also produced for the benchmark reports are tables giving the trust's score, the range of scores for each section and question, and the number of responses to each question.

Historical comparisons are made, where possible, against the 2017 survey. Arrows next to comparable questions indicate where the 2018 score is significantly higher or lower than the 2017 score. No arrow reflects no statistically significant change.

## NHS England National Statistics for England

Twenty questions from the 2018 survey contribute to the Overall Patient Experience Scores (OPES) as outlined by NHS England. The domain names included in OPES are the following:

- Access and waiting (Q6, Q7, and Q9)
- Safe, high quality, coordinated care (Q33, Q50, and Q60)
- Better information, more choice (Q34, Q57, and Q58)
- Building closer relationships (Q23, Q25, Q26, and Q28)
- Clean, friendly, comfortable place to be (Q14, Q15, Q16, Q19, Q40, Q42, and Q67)

More information is available at: [england.nhs.uk/statistics/statistical-work-areas/pat-exp/](http://england.nhs.uk/statistics/statistical-work-areas/pat-exp/).

## Quality Assurance

### Approved contractor / in-house trust checks

Each contractor and in-house trust undertakes a series of checks at key stages of the survey, especially during the sample preparation and data cleaning stages. These checks help to identify any obvious errors in the sample and response data, such as inclusion of ineligible patients or incorrect coding. Validation checks are also undertaken on mailing information in order to determine whether the patient's address is complete enough for a survey to be sent.

### Survey Coordination Centre checks

There are a number of quality assurance (QA) checks undertaken by the Survey Coordination Centre at various stages of the survey. The first QA checks are on the sample files submitted by either contractors or in-house trusts. These checks help to determine whether there are any errors in the sample file, such as the exclusion of eligible patients.

The Survey Coordination Centre also checks hard copies of the covering letters and questionnaire used by in-house trusts and contractors. This helps to identify whether any errors have been

introduced when the survey documents are reproduced. Errors are usually typographical in nature, such as misspelt or missing words, improper use of bolding (which is normally used to highlight key words), and misworded or missing response options. If an error is identified that would compromise the collected data, the Survey Coordination Centre asks the contractor or in-house trust to rectify the error and resubmit their hard copies. If mailings have already commenced then the Survey Coordination Centre will undertake investigatory analysis to determine the impact of the error on the response data such as identifying any response bias with regards to demography or patterns of response (for example, certain groups responding differently to questions as a result of the errors introduced). The investigations conclude whether the data for the question containing the error should be excluded from the final dataset and outputs for each affected trust.

During fieldwork the Survey Coordination Centre monitors the weekly progress of the mailings and response rates both at England- and trust-level. This is important because low response rates can limit the representativeness, and therefore usability, of the data. In addition, the survey needs to be administered using a standardised approach with a set number of mailings during fieldwork. If any concerns about the progress of the survey are identified, the Survey Coordination Centre will investigate the reasons for this.

The final set of QA checks undertaken by the Survey Coordination Centre focuses on the response data and analysis. In addition to the specific checks of the survey data, as outlined in the '[Data cleaning and editing](#)' section above, each stage of the data cleaning is second - and third - checked internally.

Whilst conducting these final checks, an unusual pattern in one trust's data (RLN; City Hospitals Sunderland NHS Foundation Trust) was queried and it was discovered that several errors were made in the questionnaire the trust had mailed out. Investigations were undertaken by the Survey Coordination Centre to determine the impact on the data as a result of these errors. These investigations demonstrated that for 13 questions, a level of bias had been introduced into the data collected, which undermined its quality. The decision was taken, in agreement with CQC, to exclude data from these 13 questions for this trust.

All analysis outputs based on the data (such as the trust-level results and England-level reporting) go through a two-stage QA process, checked by both the Survey Coordination Centre and CQC.

## Data limitations

### Context

As with any survey, statistical analysis of data from the Adult Inpatient Survey is susceptible to various types of error from different sources. Potential sources of error are carefully controlled through questionnaire design and sampling strategy, which is in turn supported by extensive QA at every stage of the survey.

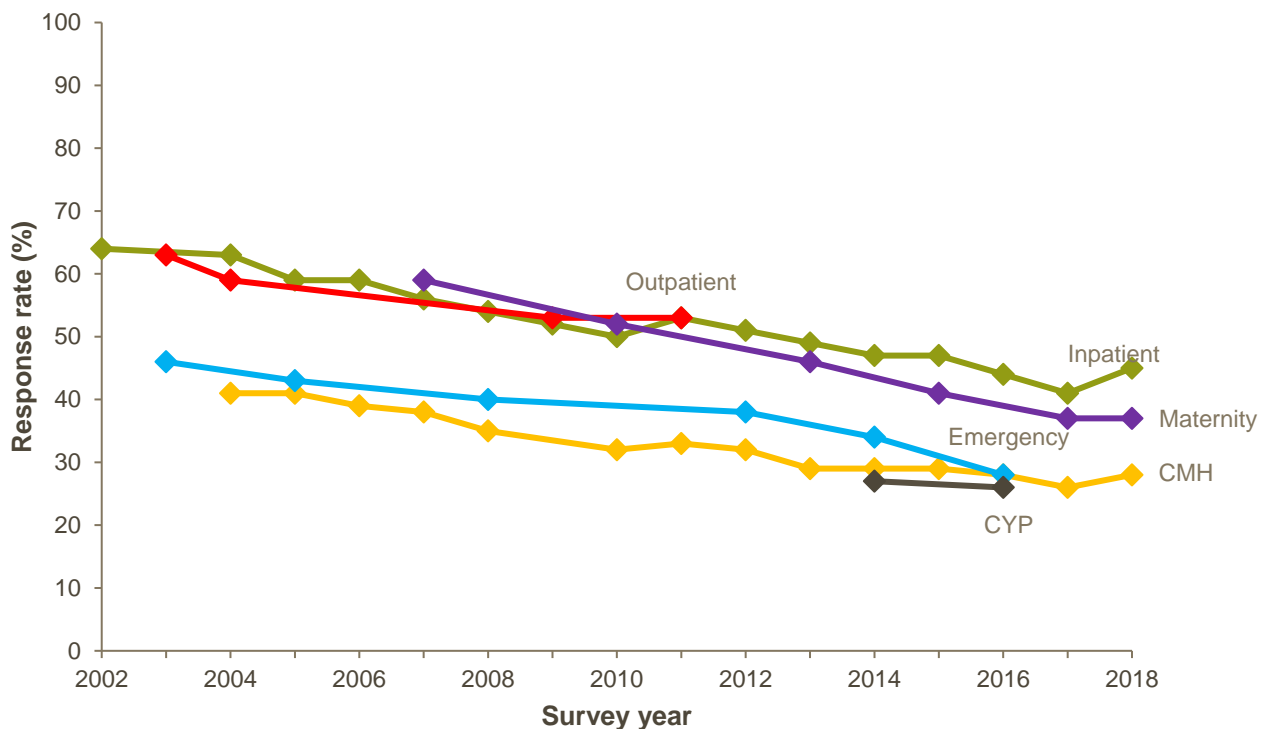
### Seasonal effects

Participating NHS Trusts selected inpatients included in the Adult Inpatient Survey who had a stay of at least one night during the month of July 2018, starting from 31st July 2018 and working backwards. Although smaller trusts were allowed to sample back to 1st January 2018, if necessary, the vast majority of patients included in the 2018 Adult Inpatient Survey received

treatment in July 2018. It is therefore possible that there may be some seasonal effects on responses; if staffing levels and other factors differ throughout the year, for example. However, given that the sampling period is the same for all trusts taking part in the survey and that the Adult Inpatient Survey has historically been sampled during the summer months, any such seasonal variation would not affect the comparability of the results over time or its use in assessing the performance of trusts.

## Response rates

Response rates for the Inpatient survey have decreased since it was first launched, from 64% in 2002 to 45% in 2018. This is consistent with other surveys in the NPSP and with industry-wide trends in social and market research. Figure 1 below illustrates response rate trends for the more established surveys in the NPSP<sup>10</sup>. The figure shows a clear downwards trend across all surveys. However, the 2018 Adult Inpatient and Community Mental Health Surveys indicate a positive change with an increase of 4 and 2 percentage points, respectively.



**Figure 1:** Response rates for established surveys in the NHS Patient Survey Programme

The CQC and Survey Coordination Centre have conducted pilot work to test different approaches aimed at increasing response rates. Most recently, three interventions were piloted alongside the 2017 Community Mental Health (CMH) Survey, with results indicating that redesigned covering letters and a redesigned questionnaire were most effective at increasing response rates. Another recent pilot was ran alongside the 2017 Adult Inpatient Survey, resulting in a significant increase in response rates with using a faster reminder letter (2 weeks reduced to 5 days). The redesigned covering letters and the faster reminder letter were adopted for the Adult Inpatient Survey 2018,

<sup>10</sup> Please note that not all surveys are carried out annually.

which may have contributed to the increase in response rate between 2017 (41%) and 2018 (45%).

## Non-response bias

One of the main issues that can affect survey results is non-response bias, and as response rates for surveys decline, the likelihood of non-response bias affecting the quality of the data increases. Non-response bias refers to the risk that those who chose to respond to the survey are different from those who chose not to respond. This type of bias would arise, for example, if patients with more positive views of their care were to be more likely to respond than those with negative views. However, whether and to what extent non-response bias is present is difficult to assess, as we do not have any way of finding out how non-responders would have answered.

A further issue is that we cannot always differentiate between those who did not receive a questionnaire and therefore could not respond, versus those who received a questionnaire but chose not to respond. The number of questionnaires that are returned undelivered are logged during the course of the survey; however, there may be another group of patients who did not receive a questionnaire but it was not returned undelivered, for example, the address was valid but was not correct address for the patient and therefore the patient did not receive the questionnaire. Unfortunately, it is not possible to know how large this group is. Furthermore, patient confidentiality prevents the Survey Coordination Centre from assessing the data quality of the addresses in the drawn samples, as they do not have access to the name and address details of those in the sample population.

Other research, including work carried out as part of the NPSP, has shown that certain groups are consistently less likely to respond, including young people, black and minority ethnic groups (BME), people from deprived areas, those with a mental health condition or poor literacy<sup>11 12 13</sup>.

Tables 1 and 2 below show that age and ethnic group response biases exist in the Adult Inpatient Survey. Table 1 shows responders and non-responders, while Table 2 shows the demographic profile for respondents and for the sample as a whole (everyone selected for inclusion in the survey). It can be seen that older patients are more likely to respond compared with other age groups, and to a lesser extent, patients who identify as white are more likely to respond than those from other ethnic groups. When interpreting these tables please bear in mind that it is likely that there are also inter-relationships between these groups.

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<sup>11</sup> [nhssurveys.org/Filestore/documents/Increasing\\_response\\_rates\\_literature\\_review.pdf](https://nhssurveys.org/Filestore/documents/Increasing_response_rates_literature_review.pdf)

<sup>12</sup> [nhssurveys.org/Filestore/documents/Review\\_BMEcoverage\\_HCC\\_surveys.pdf](https://nhssurveys.org/Filestore/documents/Review_BMEcoverage_HCC_surveys.pdf)

<sup>13</sup> [nhssurveys.org/Filestore/documents/Increasing\\_response\\_rates\\_stakeholder\\_consultation\\_v6.pdf](https://nhssurveys.org/Filestore/documents/Increasing_response_rates_stakeholder_consultation_v6.pdf)

**Table 1:** Responders and non-responders to the 2018 Adult Inpatient Survey by key demographics

Demographic	Responded (%)	
	Yes	No*
<b>Gender</b>		
Female	52	53
Male	48	47
<b>Age</b>		
16-35	5	21
36-50	8	19
51-65	23	21
66-80	41	21
>80	23	19
<b>Ethnicity**</b>		
White	94	88
Mixed	0	1
Asian or Asian British	3	6
Black or Black British	2	3
Chinese	0	0
Any other ethnic group	1	2

\* Non responders include only those with an outcome code of 4, 5 and 6

\*\* Taken from sample data

Note: Percentages are rounded to the nearest whole number - group totals may add up to more than 100%.

**Table 2:** Sample versus respondent demographic profile for the 2018 Adult Inpatient Survey

Demographic	Sample* (%)	Respondent (%)
<b>Gender</b>		
Female	53	52
Male	48	48
<b>Age</b>		
16-18	14	5
36-50	14	9
51-65	22	23
66-80	30	41
>80	21	23
<b>Ethnicity</b>		
White	91	94
Mixed	1	0
Asian or Asian British	4	3
Black or Black British	3	2
Chinese	0	0
Any other ethnic group	2	1

\* Sample figures include all patients in the trust's original sample

Note: Percentages are rounded to the nearest whole number - group totals may add up to more than 100%.



## Addressing potential non-response bias in the survey results

Non-response weighting is currently applied to the England-level data, but not the trust-level data. In considering whether to weight for non-response and whether this should be according to either the sample or population data, we need to factor in the primary aim of collecting the survey data.

For the majority of social research studies, in particular those that are cross-sectional or general population studies, non-response is weighted for against the target population demographics. This is normally achieved by weighting for key characteristics such as age, gender, marital status and socio-economic status, if this auxiliary data exists on the sampling frame. Weighting is used to eliminate, or at least reduce, total non-response bias. In a non-response approach, a model is developed to estimate unknown response probabilities with weights adjusted to the estimated response probabilities. Units with the same characteristics and the same propensity to respond are grouped together to protect against model insufficiency<sup>14</sup>. Alternatively, if an England-level dataset exists for these key characteristics, such as the census for national population estimates, then this can be used in deriving the weighting approach. The reason why weighting back to the population is key for these studies is that they are looking to make generalisations about a population as a whole rather than individual cases or sampling units within it.

Our weighting strategies are detailed in the sections below.

## Trust-level benchmark analysis

For the NPSP, the data collected is used for measuring and comparing the performance of individual NHS trusts. Therefore it is important that we are able to distinguish between the characteristics of different trusts (i.e. the variation between them) to identify those trusts that are doing better or worse than the 'average' trust. As characteristics such as gender, age and the route of admission (whether someone was an emergency or elective patient) are known to be related to responses, we therefore standardise different organisations to a common average case-mix when calculating organisational results. This removes demographic differences as a source of variation and provides a 'level playing field' for comparing providers. Weighting for non-response to either an England-level population dataset or back to the sample data for a trust would not achieve this.

Differences between trust populations in the Adult Inpatient Survey are partly addressed via standardising by gender, age and route of admission in the trust-level results<sup>15</sup>. Standardising by ethnicity would in theory also improve comparability, however whether to do this is subject to a number of considerations detailed below.

The more variables included in the standardisation, the more complex the analysis becomes. It also greatly increases the risk of having very small groups with large weights. In order to weight by a certain variable, we need to have information for that variable for each respondent. Information for gender, age and route of admission is largely complete, with only very few, if any, missing cases for these variables. In 2018 all respondents had data for gender and age (taken from response data, or sample data if response data were missing); though 585 respondents were missing route of admission information (taken from Q1). However, ethnicity information (which is only taken from

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<sup>14</sup> [statcan.gc.ca/pub/12-539-x/2009001/response-reponse-eng.htm](http://statcan.gc.ca/pub/12-539-x/2009001/response-reponse-eng.htm).

<sup>15</sup> For more information on the methodology for the trust-level results, please see the technical document which is referenced in the 'Further Information' section at the end of this document.

response data due to data quality concerns about sample data) is less complete. If we were to additionally standardise by ethnicity, we would have to remove people from the analysis in 2018, which is not desirable, particularly in a survey with already low response rates.

Some trusts have very low proportions of people in some ethnic groups. As weights are capped to avoid heavy weighting<sup>16</sup>, this would lead to many respondents having capped weights. This should be avoided as far as possible when standardising data as it limits the comparisons that can be made<sup>17</sup>

It should be noted that direct assessment of non-response bias upon survey data is difficult to measure due to the obvious ethical implications of acquiring such data. This would require further contact with patients who do not wish to be contacted. Rather than further adjusting the data, this issue is managed by adopting best-practice methodologies so as to maximise response rates from all groups, as discussed in the '[Survey design and implementation](#)' section of this report.

## Results for England

Some trusts have a higher response rate than others and would therefore have a greater influence over the England average if a simple mean was calculated across all respondents. To avoid this, 'trust' weights are applied to the England-level data. Doing so means that each trust has an equal influence over the England average for each question, regardless of differences in response rates between trusts.

Additional 'population' weights were also introduced in the 2017 survey, with the aim of reducing potential non-response bias. This involved weighting by age groups, route of admission and gender so that the weighted proportions in each age group in the respondent population match those in the sampled population. Increased weight is therefore given to groups that had lower propensity to respond. A single population weight was computed for each respondent.

As the 2018 England-level results present trend comparisons across surveys from 2009 to 2018, it was also necessary to weight the historic data in the same way as for the current year. Population weights and trust weights were multiplied together to produce a single, combined weight for each question and this was applied when generating the national tables for England<sup>18</sup>.

Assuming that responses were missing at random, weighting each trust's results to their eligible population in this way theoretically makes the trust's results more representative of their population, thus potentially yielding a more accurate experience of the average trust. However, it is not possible to check the extent to which this 'missing at random' assumption is satisfied.

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<sup>16</sup> To prevent the possibility of excessive weight being given to respondents in an extremely underrepresented group, the maximum value for any weight was set at five.

<sup>17</sup> Potter F. (1990), A study of procedures to identify and trim extreme sample weights, Proceeding of the Survey Research Methods Section, American Statistical Association, pp.225-230.

<sup>18</sup> As this approach was new in 2017, the England-level results for the 2009 – 2016 Adult Inpatient Surveys will differ slightly from the trend comparison results in the 2017 and 2018 England-level results. .

The introduction of non-response weights to the England-level results is a 'design effect' that reduces the precision of statistics from the survey. This has been taken into account for year-to-year comparisons. The design effect can be estimated as the following, where  $w_i$  is the weight for respondent  $i$  and  $n_{total}$  is the total number of respondents:

$$DEFF = \frac{n_{total} * [\sum_i w_i^2]}{[\sum_i w_i]^2}$$

This is then used to adjust the alpha value for the tests of column proportions in national tables for England, using  $\alpha_{new} = 2$ -tailed probability for a result at least as extreme as  $|1.95996398454 \times \sqrt{DEFF}|$ .

This weighting has been applied to the England-level results for all except the demographic questions. These questions are presented without weights applied, as it is more appropriate to present unadjusted data that describes the demographic profile of respondents, rather than average figures.

## Data revisions

CQC publishes a [Revisions and Corrections Policy](#) relating to these statistics. This policy sets out how CQC will respond if an error is identified and it becomes necessary to correct published data and/or reports. The NPSP data is not subject to any scheduled revision as the surveys capture the views of patients about their experiences of care at a specific point in time. All new survey results are therefore published on CQC's website and the NHS Surveys website, as appropriate, and previously published results for the same survey are not revised.

## Further information

The England-level and trust-level results can be found on the CQC website. You can also find a 'technical document' here which describes the methodology for analysing trust-level results:

<https://www.cqc.org.uk/surveys/inpatient>

The England and trust-level results from previous Inpatient Surveys that took place between 2002 and 2018 are available at the link below:

<http://www.nhssurveys.org/surveys/425>

Full details of the methodology for the survey, including questionnaires and covering letters, instructions on how to carry out the survey, and the survey development report, are available at:

<http://www.nhssurveys.org/surveys/1203>

More information on the NPSP, including results from other surveys and a programme of current and forthcoming surveys, can be found at:

[cqc.org.uk/content/surveys](http://cqc.org.uk/content/surveys)

# Feedback

We welcome all feedback on the survey findings and the approach we have used to report the results, particularly from people using services, their representatives, and those providing services. If you have any views, comments or suggestions on how this publication could be improved, please contact Tamatha Webster, Survey Manager, at [patient.survey@cqc.org.uk](mailto:patient.survey@cqc.org.uk).

The information you provide will be reviewed by CQC and used, as appropriate, to improve the statistics that we publish across the NHS Patient Survey Programme.

# Appendix A: 2018 Questionnaire



## INPATIENT QUESTIONNAIRE

### What is the survey about?

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

### Who should complete the questionnaire?

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

### Completing the questionnaire

For each question please cross  clearly inside one box using a black or blue pen. For some questions you will be instructed that you may cross more than one box.

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

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

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

### Questions or help?

If you have any queries about the questionnaire, please call our helpline number:

<Insert helpline number here>

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

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

### ADMISSION TO HOSPITAL

1. Was your most recent hospital stay planned in advance or an emergency?
  - 1  Emergency or urgent → Go to 2
  - 2  Waiting list or planned in advance → Go to 5
  - 3  Something else → Go to 2

### THE ACCIDENT & EMERGENCY DEPARTMENT

2. When you arrived at the hospital, did you go to the A&E Department (also known as the Emergency Department, Casualty, Medical or Surgical Admissions unit)?
  - 1  Yes → Go to 3
  - 2  No → Go to 5
3. While you were in the A&E Department, how much information about your condition or treatment was given to you?
  - 1  Not enough
  - 2  Right amount
  - 3  Too much
  - 4  I was not given any information about my treatment or condition
  - 5  Don't know / can't remember
4. Were you given enough privacy when being examined or treated in the A&E Department?
  - 1  Yes, definitely
  - 2  Yes, to some extent
  - 3  No
  - 4  Don't know / can't remember

**EMERGENCY & URGENTLY ADMITTED PATIENTS, now please go to Question 9**

**WAITING LIST & PLANNED ADMISSION PATIENTS, please continue to Question 5**

### WAITING LIST OR PLANNED ADMISSION

5. When you were referred to see a specialist, were you offered a choice of hospital for your **first hospital appointment**?
  - 1  Yes
  - 2  No, but I would have liked a choice
  - 3  No, but I did not mind
  - 4  Don't know / can't remember
6. How do you feel about the length of time you were on the waiting list before your admission to hospital?
  - 1  I was admitted as soon as I thought was necessary
  - 2  I should have been admitted a bit sooner
  - 3  I should have been admitted a lot sooner
7. Was your admission date changed by the hospital?
  - 1  No
  - 2  Yes, once
  - 3  Yes, 2 or 3 times
  - 4  Yes, 4 times or more

8. In your opinion, had the specialist you saw in hospital been given all of the necessary information about your condition or illness from the person who referred you?

- 1  Yes, definitely
- 2  Yes, to some extent
- 3  No
- 4  Don't know / can't remember

### ALL TYPES OF ADMISSION

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

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

### THE HOSPITAL & WARD

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

- 1  Yes
- 2  No
- 3  Don't know / can't remember

11. While in hospital, did you ever share a sleeping area, for example a room or bay, with patients of the opposite sex?

- 1  Yes
- 2  No

12. Did you change wards at night?

- 1  Yes, but I would have preferred not to → Go to 13
- 2  Yes, but I did not mind → Go to 13
- 3  No → Go to 14

13. Did the hospital staff explain the reasons for being moved in a way you could understand?

- 1  Yes, completely
- 2  Yes, to some extent
- 3  No

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

- 1  Yes
- 2  No

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

- 1  Yes
- 2  No

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

- 1  Very clean
- 2  Fairly clean
- 3  Not very clean
- 4  Not at all clean

**17.** Did you get enough help from staff to wash or keep yourself clean?

- 1  Yes, always
- 2  Yes, sometimes
- 3  No
- 4  I did not need help to wash or keep myself clean

**18.** If you brought your own medication with you to hospital, were you able to take it when you needed to?

- 1  Yes, always
- 2  Yes, sometimes
- 3  No
- 4  I had to stop taking my own medication as part of my treatment
- 5  I did not bring my own medication with me to hospital

**19.** How would you rate the hospital food?

- 1  Very good
- 2  Good
- 3  Fair
- 4  Poor
- 5  I did not have any hospital food

**20.** Were you offered a choice of food?

- 1  Yes, always
- 2  Yes, sometimes
- 3  No

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

- 1  Yes, always
- 2  Yes, sometimes
- 3  No
- 4  I did not need help to eat meals

**22.** During your time in hospital, did you get enough to drink?

- 1  Yes
- 2  No, because I did not get enough help to drink
- 3  No, because I was not offered enough drinks
- 4  No, for another reason

## DOCTORS

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

- 1  Yes, always
- 2  Yes, sometimes
- 3  No
- 4  I had no need to ask

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

- 1  Yes, always
- 2  Yes, sometimes
- 3  No



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

- 1  Yes, often
- 2  Yes, sometimes
- 3  No

## NURSES

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

- 1  Yes, always
- 2  Yes, sometimes
- 3  No
- 4  I had no need to ask

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

- 1  Yes, always
- 2  Yes, sometimes
- 3  No

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

- 1  Yes, often
- 2  Yes, sometimes
- 3  No

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

- 1  There were always or nearly always enough nurses
- 2  There were sometimes enough nurses
- 3  There were rarely or never enough nurses

30. Did you know which nurse was in charge of looking after you (this would have been a different person after each shift change)?

- 1  Yes, always
- 2  Yes, sometimes
- 3  No

## YOUR CARE & TREATMENT

31. Did you have confidence and trust in any **other clinical staff** treating you (e.g. physiotherapists, speech therapists, psychologists)?

- 1  Yes, always
- 2  Yes, sometimes
- 3  No
- 4  I was not seen by any other clinical staff

32. In your opinion, did the members of staff caring for you work well together?

- 1  Yes, always
- 2  Yes, sometimes
- 3  No
- 4  Don't know / can't remember

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

- 1  Yes, often
- 2  Yes, sometimes
- 3  No

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

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

35. Did you have confidence in the decisions made about your condition or treatment?

- 1  Yes, always
- 2  Yes, sometimes
- 3  No

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

- 1  Not enough
- 2  Right amount
- 3  Too much
- 4  I was not given any information about my treatment or condition
- 5  Don't know / can't remember

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

- 1  Yes, definitely
- 2  Yes, to some extent
- 3  No
- 4  I had no worries or fears

38. Do you feel you got enough emotional support from hospital staff during your stay?

- 1  Yes, always
- 2  Yes, sometimes
- 3  No
- 4  I did not need any emotional support

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

- 1  Yes, always
- 2  Yes, sometimes
- 3  No

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

- 1  Yes, always
- 2  Yes, sometimes
- 3  No

41. Were you ever in any pain?

- 1  Yes  
→ Go to 42
- 2  No  
→ Go to 43

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

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

43. If you needed attention, were you able to get a member of staff to help you **within a reasonable time**?

- 1  Yes, always
- 2  Yes, sometimes
- 3  No
- 4  I did not want / need this

## OPERATIONS & PROCEDURES

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

- 1  Yes → **Go to 45**
- 2  No → **Go to 48**

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

- 1  Yes, completely
- 2  Yes, to some extent
- 3  No
- 4  I did not have any questions

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

- 1  Yes, completely
- 2  Yes, to some extent
- 3  No

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

- 1  Yes, completely
- 2  Yes, to some extent
- 3  No

## LEAVING HOSPITAL

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

- 1  Yes, definitely
- 2  Yes, to some extent
- 3  No
- 4  I did not want to be involved

49. Were you given enough notice about when you were going to be discharged?

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

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

- 1  Yes → **Go to 51**
- 2  No → **Go to 53**

51. What was the **MAIN** reason for the delay? (**Cross ONE box only**)

- 1  I had to wait for **medicines**
- 2  I had to wait to **see the doctor**
- 3  I had to wait for an **ambulance**
- 4  Something else

52. How long was the delay?

- 1  Up to 1 hour
- 2  Longer than 1 hour but no longer than 2 hours
- 3  Longer than 2 hours but no longer than 4 hours
- 4  Longer than 4 hours

53. Where did you go after leaving hospital?

- 1  I went home → Go to 54
- 2  I went to stay with family or friends → Go to 54
- 3  I was transferred to another hospital → Go to 55
- 4  I went to a residential nursing home → Go to 55
- 5  I went somewhere else → Go to 55

54. After leaving hospital, did you get enough support from health or social care professionals to help you recover and manage your condition?

- 1  Yes, definitely
- 2  Yes, to some extent
- 3  No, but support would have been useful
- 4  No, but I did not need any support

55. When you left hospital, did you know what would happen next with your care?

- 1  Yes, definitely
- 2  Yes, to some extent
- 3  No
- 4  It was not necessary

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

- 1  Yes
- 2  No

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

- 1  Yes, completely → Go to 58
- 2  Yes, to some extent → Go to 58
- 3  No → Go to 58
- 4  I did not need an explanation → Go to 58
- 5  I had no medicines → Go to 60

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

- 1  Yes, completely
- 2  Yes, to some extent
- 3  No
- 4  I did not need an explanation

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

- 1  Yes, completely
- 2  Yes, to some extent
- 3  No
- 4  I did not need this
- 5  Don't know / can't remember

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

- 1  Yes, completely
- 2  Yes, to some extent
- 3  No
- 4  It was not necessary

61. Did hospital staff take your family or home situation into account when planning your discharge?

- 1  Yes, completely
- 2  Yes, to some extent
- 3  No
- 4  It was not necessary
- 5  Don't know / can't remember

62. Did the doctors or nurses give your family, friends or carers all the information they needed to help care for you?

- 1  Yes, definitely
- 2  Yes, to some extent
- 3  No
- 4  No family, friends or carers were involved
- 5  My family, friends or carers did not want or need information
- 6  I did not want my family, friends or carers to get information

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

- 1  Yes
- 2  No
- 3  Don't know / can't remember

64. Did hospital staff discuss with you whether you would need any additional equipment in your home, or any adaptations made to your home, after leaving hospital?

- 1  Yes
- 2  No, but I would have liked them to
- 3  No, it was not necessary to discuss it

65. Did hospital staff discuss with you whether you may need any further health or social care services after leaving hospital (e.g. services from a GP, physiotherapist or community nurse, or assistance from social services or the voluntary sector)?

- 1  Yes
- 2  No, but I would have liked them to
- 3  No, it was not necessary to discuss it

66. Was the care and support you expected available **when** you needed it?

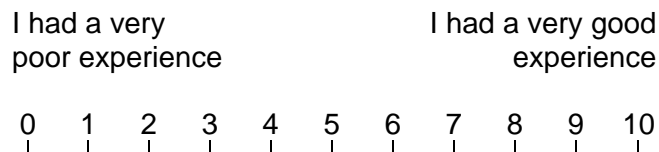
- 1  Yes
- 2  No
- 3  I did not expect any further care or support after I was discharged

## OVERALL

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

- 1  Yes, always
- 2  Yes, sometimes
- 3  No

68. Overall... (Please circle a number)



69. During this hospital stay, did anyone discuss with you whether you would like to take part in a research study?

- 1  Yes, and I agreed to take part
- 2  Yes, but I did not want to take part
- 3  No
- 4  Don't know / can't remember

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

- 1  Yes
- 2  No
- 3  Don't know / can't remember

71. Did you see, or were you given, any information explaining how to complain to the hospital about the care you received?

- 1  Yes
- 2  No
- 3  Not sure / don't know

72. Did you feel well looked after by the **non-clinical** hospital staff (e.g. cleaners, porters, catering staff)?

- 1  Yes, always
- 2  Yes, sometimes
- 3  No
- 4  I did not have contact with any non-clinical staff

## ABOUT YOU

73. Who was the main person or people that filled in this questionnaire?

- 1  The **patient** (named on the front of the envelope)
- 2  A **friend or relative** of the patient
- 3  **Both** patient and friend/relative together
- 4  The patient with the help of a health professional

**Reminder:** All the questions should be answered from the point of view of the person named on the envelope. This includes the following background questions.

74. Do you have any physical or mental health conditions, disabilities or illnesses that have lasted or are expected to last for 12 months or more?

Include problems related to old age.

- 1  Yes → **Go to 75**
- 2  No → **Go to 77**

75. Do you have any of the following?

Select **ALL** conditions you have that have lasted or are expected to last for 12 months or more.

- 1  Breathing problem, such as asthma
- 2  Blindness or partial sight
- 3  Cancer in the last 5 years
- 4  Dementia or Alzheimer's disease
- 5  Deafness or hearing loss
- 6  Diabetes
- 7  Heart problem, such as angina
- 8  Joint problem, such as arthritis
- 9  Kidney or liver disease
- 10  Learning disability
- 11  Mental health condition
- 12  Neurological condition
- 13  Another long-term condition

76. Do any of these reduce your ability to carry out day-to-day activities?

- 1  Yes, a lot
- 2  Yes, a little
- 3  No, not at all

77. Are you male or female?

- 1  Male
- 2  Female

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

(Please write in) e.g. 

1	9	3	4
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Y	Y	Y	Y
---	---	---	---

79. What is your religion?

- 1  No religion
- 2  Buddhist
- 3  Christian (including Church of England, Catholic, Protestant, and other Christian denominations)
- 4  Hindu
- 5  Jewish
- 6  Muslim
- 7  Sikh
- 8  Other
- 9  I would prefer not to say

80. Which of the following best describes how you think of yourself?

- 1  Heterosexual / straight
- 2  Gay / lesbian
- 3  Bisexual
- 4  Other
- 5  I would prefer not to say

81. What is your ethnic group? (**Cross ONE box only**)

**a. WHITE**

- 1  English / Welsh / Scottish / Northern Irish / British
- 2  Irish
- 3  Gypsy or Irish Traveller
- 4  Any other White background, **write in...**

**b. MIXED / MULTIPLE ETHNIC GROUPS**

- 5  White and Black Caribbean
- 6  White and Black African
- 7  White and Asian
- 8  Any other Mixed / multiple ethnic background, **write in...**

**c. ASIAN / ASIAN BRITISH**

- 9  Indian
- 10  Pakistani
- 11  Bangladeshi
- 12  Chinese
- 13  Any other Asian background, **write in...**

**d. BLACK / AFRICAN / CARIBBEAN / BLACK BRITISH**

- 14  African
- 15  Caribbean
- 16  Any other Black / African / Caribbean background, **write in...**

**e. OTHER ETHNIC GROUP**

- 17  Arab
- 18  Any other ethnic group, **write in...**

## OTHER COMMENTS

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

*Please note that the comments you provide will be looked at in full by the NHS Trust, CQC and researchers analysing the data. We will remove any information that could identify you before publishing any of your feedback.*

Was there anything particularly good about your hospital care?

Was there anything that could be improved?

Any other comments?

**THANK YOU VERY MUCH FOR YOUR HELP**

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

**Please post this questionnaire back in the FREEPOST envelope provided.  
No stamp is needed.**

**If you do not have your FREEPOST envelope, please return the questionnaire to:**

**FREEPOST XXXX-XXXX-XXXX,  
Address,  
Address,  
Address,  
Address,**

**If you have concerns about the care you or others have received please  
contact CQC on 03000 61 61 61**