Details of feedback from CQC's consultation on proposed changes to the NHS Patient Survey Programme

November 2016

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Introduction

This report provides detailed feedback received from CQC's consultation on proposed changes to the NHS Patient Survey Programme, which ran from 26 May to 21 July 2016.

We received 204 responses in total - some from individuals and others submitted on behalf of a whole team or organisation. We asked individual respondents about their 'roles' to help us understand more about the type of people who use the surveys and to interpret their comments.

The responses to our proposals ranged from general comments about the design of the surveys programme as a whole to specific benefits or challenges for each recommended change.

We have analysed the written feedback and identified the main themes that emerged from the comments, which we present in this report under headings according to those themes. The themes vary according to the question, as they are based on the issues that respondents raised when answering each specific consultation question.

A glossary is available at the end of this document, to help in understanding the terms used.

Themes from the consultation feedback

Q1: Discontinue the outpatient survey and instead incorporate relevant questions into the adult inpatient survey

Sampling

Benefits

Positive commentary on this issue among all respondents was very limited (two comments only) compared with the volume of commentary about the challenges. A service provider said that there would be 'improved sample sizing' in the new survey and a respondent from a medical professional body said that this "…would be a good thing. Increasing sample size is an important factor in determining the accuracy of data."

Challenges

The most common challenge mentioned by respondents in all roles – from charities, national and regional bodies, members of the public and service providers – was the exclusion of outpatients who did not attend as inpatients. One service provider suggested that the eligibility to receive a survey should be reviewed to ensure that the views of outpatients are still captured.

Furthermore, concerns were raised that the proposed change to the survey would introduce a bias in the information obtained. A service provider stressed the importance of outpatient data and why they should not be excluded, saying, "it seems that outpatients is being treated as less important than other areas of care - which re-enforces how many trusts view outpatient services… many patients have poor experiences in outpatients and [this] leads to their first impressions of the hospital."

Respondents gave examples of the groups of patients who they thought would be excluded from the combined survey: People who entered hospital as an emergency, people suffering from long-term conditions such as asthma, people attending for diagnostic procedures, dialysis, and dental, mental health, sexual health, chemotherapy and radiotherapy services.

This point was also expressed in terms of the volume of patients that would be excluded from the proposed survey. A service provider noted that "Most [in]patients are emergency admission" and do not go through outpatients. A respondent from a research organisation noted that there were over six times as many outpatient appointments as completed inpatient episodes. These

comments imply that a high proportion of overall outpatient experiences would be excluded.

A service provider and research organisation stated that data would be biased because the 'themes and demographics' of outpatients and inpatients are different. Another service provider said that "Inpatients are more likely to be elective patients who generally have a better experience". A respondent from a national body said that, "…the responses would not be representative of the outpatient population" and "they could not be adjusted for this due to the number of outpatients who are not admitted".

A respondent from a research organisation noted an additional bias generated from the method of surveying inpatients. This respondent explained that inpatients are surveyed about their most recent outpatient episodes after having been recently discharged following an inpatient stay. Therefore, the responses to the survey would be biased towards outpatient check-ups, which represent the minority of all outpatient episodes. A member of the public also commented that the proposed survey would not give their outpatient experience "appropriate weighting".

Response rates and reliability

Benefits

The main benefit identified by a few respondents (mainly service providers, one from a charity and one regional body) was having one survey instead of two. This would help reduce 'survey fatigue' where patients are disinclined to complete questionnaires because they are overloaded with requests. However, it must be noted that the current survey cycle means there would be minimal overlap in terms of the same individuals being included in both the inpatient and outpatient surveys. If any patients did receive both surveys, there would be some time lag between receiving each questionnaire.

Challenges

A few respondents, mainly service providers, said that a questionnaire about inpatient and outpatient care could be longer, or contain some irrelevant questions. This could put people off completing it and therefore reduce response rates.

A number of service providers (and a respondent from a research organisation) also pointed out that the combined survey could become more complex and confusing for people and would be difficult for people to respond accurately. They might instead get confused about which outpatient experience they were referring to and not know or recall which provider it related to. This is because people often attend more than one outpatient appointment, and this could be in different provider organisations. A service provider pointed out that this may be a more prominent issue in London when providers are geographically closer and people are more likely to attend different trusts as part of the same overall care episode – described by one service provider as 'cross-trust pathways'.

A couple of respondents mentioned the issue of timing. A service provider said that people may have forgotten the outpatient experience by the time they

become receive a questionnaire for the inpatient survey, so the answers could be less accurate.

Monitoring and improving services

Benefits

Two service providers agreed with the proposed approach *in principle*. For example, the two surveys would be "streamlined into one survey reflecting joined-up care" and it would be a "unified approach to service provision and gaining feedback related to the same."

A common issue among respondents was whether the proposed survey would yield 'better data' (patient group). The most common explanations for *how* the data would be 'better' was that it would cover pathways of care. For example, it "includes the pre-admission and post-discharge part of the patient's journey" (service provider). The majority of these comments were from service providers, although a respondent from a national body also mentioned this. Some service providers further explained how this would be more useful for monitoring. For example, the inpatient and outpatient data would be "held in one place" and the outpatient data could be "read in line with inpatient data."

Other explanations of how data would be better were that it would be more regular (mentioned by service providers and a respondent from a commissioning body). For example, "It would mean that feedback from patients attending outpatient clinics would be received every year which is good…" (service provider). Another service provider noted that more regular data would "enable actions implemented to be monitored more effectively through enhanced reporting mechanisms."

A wide range of respondents (those from organisations, individuals and one service provider) mentioned that the data would be more targeted and focused. For example, it would be "more succinct" (national body); it would "enable more targeted information to be gathered" (charity); and an individual stated that from their perspective, "I can have more to say about what I think is relevant."

A respondent from a national body suggested that there would be *more data* from the proposed survey because there would be more responses. This would provide "a more sophisticated view of what different specific groups of people are saying about their healthcare experiences and care." ('Sophisticated' is interpreted to mean that conclusions on this are more reliable as there is more data to base the findings on.)

Challenges

Respondents, from regional and national bodies as well as service providers, were concerned about the loss of data in the proposed survey. Firstly, there were concerns whether there would be "sufficient data" (national body), or whether it would be detailed enough (a regional body and service providers). The respondent from a national body expressed concerns over the effect of the combined survey "on the time-series and year on year comparability [of data] both at a trust and national level." A service provider said, "Providing the

outpatients survey information is a vital part of meeting this patients groups needs both today and in the future."

There were concerns that the combined survey might yield less data on inpatients specifically; a respondent from a research organisation suggested that questions on the inpatient survey "could not be dropped" (to make room for outpatients questions). A respondent from a national body said that it might be harder to compare inpatient data with previous years (if the data to be collected is reduced).

Similarly, a respondent from a regional body and two service providers had concerns that outpatient data may be lost, or become less detailed. A respondent from a commissioning body said that the "Lack of a specific OP survey poses the danger of those patients not being able to feed back about the specific issues they face in accessing OP services in particular, which is considerable...Trust complaints usually have a significant number of cases relating specifically to appointment systems for outpatients, the availability of information in such appointments, follow up arrangements and poor communication issues between organisations and internal departments. The detail may be lost."

Conversely, one service provider suggested that the combined survey might yield too much data. "Too much information/patient feedback may prove a challenge in identifying the areas for improvement."

Respondents from a national body, a research organisation, and a number of service providers commented on the problem of attributing findings to particular services or providers in a combined survey. This relates to people getting confused about which service they are referring to or which experience they are reporting on (see earlier section on response reliability). For example, a service provider said, "Combining outpatient and inpatient feedback in one survey would further reduce confidence in where responses have come from." A respondent from a national body pointed out a further difficulty, "…the condition with which a patient was visiting outpatients is different to that covering their inpatient stay, meaning interpretation and understanding of the data would be difficult."

Survey logistics, costs and workload

Benefits

Comments on this were from service providers, commissioning groups and members of the public. They viewed the reduction of surveys from two to one as a benefit in terms of the cost savings, less work in administering a second separate survey, and for patients having to fill in only one survey. Some noted that this would prevent duplication "for both staff and patients".

Challenges

Respondents in a range of roles were uncertain as to the precise design of the proposed combined survey. Respondents (mainly service providers but also a respondent from a national body) appeared uncertain whether the outpatient survey questions would be added on to the inpatient questionnaire, or if the entire survey questionnaire would be redesigned. (The implications for the survey length are explained in the response rate section). For example, "…would survey

managers increase their costs given the increase in size of the survey? Or would there be a total change in the question format for inpatients too?" (service provider). A respondent from a research organisation said that it would be "a challenge" to incorporate outpatient questions into the inpatient questionnaire.

A service provider commented on logistical problems of identifying the sample (inpatients who have had outpatient experiences) as their data warehouse does not link inpatients and outpatients.

Disseminating results and changes to services

Benefits

Only service providers commented on how results are disseminated. They said the combined survey would generate a single report, which would help increase staff engagement, "…currently it is challenging to run a whole trust event for IP where staff from outpatients may feel that it is not relevant to them/their area." A respondent from a regional body said that combining two surveys would generate "consistency and that the same quality of service is delivered to patients in either setting."

Challenges

Respondents from a regional body and a research organisation each commented that it would be difficult to attribute results to individual service providers. A service provider also said that it would be difficult for staff within their trust to take ownership of the results "when [the] spread between inpatients and outpatients includes electives and emergency pathways". Another said, "…some specialties are very outpatient based – they [staff] will be less inclined to engage with the results of the inpatient survey as [they] will believe that it is not representative of their areas."

One service provider noted the same problem when accessing the results: "It will be important for community trusts with outpatient services to be made aware that they will [need to] access these reports via an inpatient survey that they may not have already been accessing."

A respondent from a research organisation said that it might adversely influence the behaviour of providers by adding: "…incentives for trusts to provide disproportionately better outpatient care for patients most likely to be admitted, thereby diverting resources away from those who are unlikely to be admitted."

Q2: Review the A&E survey to include all relevant urgent care services (for example, A&E departments, GP out-of-hours services, urgent care centres, NHS 111, and ambulance services)

Survey logistics

Benefits

There were a few positive comments (mainly from service providers) on this issue, who said that reporting would be "more streamlined" and there would be "a clear timetable".

Challenges

The major concern for many respondents was the logistics of running a broader urgent care survey. Respondents cited many more challenges than benefits. In terms of the overall survey design, a service provider and a respondent from a medical professional body felt that the new survey should be designed to reflect new models of care, for example "the development of Local Partnerships".

However, more specific logistical difficulties were specified with sampling across different services. A respondent from a research organisation said, "…there are considerable differences in the way urgent and emergency care services are structured across the acute and ambulance sectors, and care will be needed in moving from a survey of the relatively homogeneous major A&E department setting to a broader coverage." More than one service provider and a respondent from a research organisation mentioned the problem of sampling. They stated, "This may eventually require sampling from multiple organisation types" though a service provider noted that "The data for these services are hosted on different systems. I'm not sure these could be combined if required."

Two respondents commented on problems with designing the questionnaire and "…how to design an assessment tool that is generic enough to cover any urgent care setting but at the same time is specific enough to provide meaningful results." (national body). A research organisation also commented, "NHS 111 stands out as a particular example of a service that operates very differently from others: users will often not see any health professional as part of an episode." Therefore, it would be difficult to design generic questions about care across all healthcare settings when the type of staff and the methods of interacting with them are so different.

To solve the problem of the complexity of the proposed survey, a respondent from a research organisation suggested that an "evolutionary approach be taken and the new survey be broadened initially to include only emergency care provided by acute trusts. For example, minor injuries units and hospital walk-in centres."

A respondent from a research organisation suggested that the questionnaire would need to be longer to ensure enough information for each of the additional services. This respondent and some service providers noted that this would cost more, or involve more work.

A service provider mentioned that the logistics of reporting the data would be more complicated, as the urgent care services being reported on in this single survey would relate to multiple providers, "Would it [the report] be one document or many individual ones that then feed into a final summary which is shared[?]"

Response rates and reliability

Challenges

The perception among respondents was that the response rate would fall if the questionnaire gets longer or becomes more complex, as it would put people off completing it: "CQC must be careful to ensure that this does not result in a sprawling, complex survey instrument. Response rates to the national A&E survey are already lower than for the adult inpatient survey and the widening of sample to include other urgent care services where patients conditions are often less serious could realistically be expected to drive this down further." (research organisation).

Monitoring and improving services

Benefits

A large proportion of respondents commented positively about monitoring services. Respondents cited the changing provider context as justification for introducing this survey. A service provider commented that the proposed survey should "reflect the changing emergency care environment so that it remains 'fit for purpose'." Also, "given the increase in the different types of urgent care services available to people, it is logical to also collate feedback about these services" (national body). A respondent from a different national body said, "It will provide a wider view across the emergency care landscape" and felt that it would "make more sense to look at the whole urgent care system - particularly as patients do not necessarily see boundaries to services."

The most common benefit mentioned by almost half of all respondents to this consultation, in all roles, was that the proposed survey would provide a *broader* and more *joined-up* view of care. Service providers, a national body, regional bodies and charities commented that it would yield more inclusive data about the whole patient journey. A service provider explained that this was a benefit because service provision is "a process not a series of services…" One of many members of the public said that from their perspective it would "allow you to give your overall opinion".

Respondents commented on the usefulness of having more inclusive data on services, and the analysis that could be done with a broader dataset. The point raised by most of these respondents, particularly service providers, was the ability to understand why patients choose to use particular emergency care

services. This was summarised by one service provider who noted "…the potential [is] to provide greater insight into the route into an acute hospital setting. It could assist acute trust providers in working with partners outside on improving or reducing those patients who do not need to visit an acute setting." A couple of service providers said it "…may help towards more collaborative working and engagement by the providers."

Challenges

Attribution to individual service providers

Respondents from national bodies, research organisations and service providers said it would be necessary, but also difficult, to attribute the findings to individual providers and services. For example, "It is also likely to be a complex survey in terms of sampling and assigning a patient's experience to a specific organisation / service." (service provider). It was felt this would be difficult for those completing the survey "…when patients/carers want to raise a concern/complaint about their care, they come to the [name of hospital] as they think that as the service is based here that we are responsible for it." (service provider).

It was also noted that the results would only be useful "if managers and clinicians recognise the results as belonging to them." (research organisation). A service provider was unclear whether individual providers would be held responsible for "their part of the pathway". For example, where a patient arrives at A&E very angry from a bad experience with NHS 111, the A&E provider may be held responsible or suffer damage to their reputation, even though the 'root cause' is NHS 111.

One respondent noted that the issue of attribution is also relevant to attributing costs, "…acute trusts are unlikely to want to pay for an NHS 111 survey." (research organisation).

Comparisons with previous surveys or other data

Service providers and respondents from a charity, a research organisation and a national body said that adding data about new services to future surveys might make it difficult to compare with data from previous surveys. The respondent from a charity explained this most clearly: "We understand that changing the services measured by the survey could mean that new survey results are harder to compare with past results." A service provider said it was necessary to "…ensure that the results are analysed by location as Urgent Care Units often get tendered out and the provider may change over time".

Q3: Include the children and young people's (CYP) survey in the regular programme

Listening to children and young people

Benefits

Respondents, not just members of the public but also service providers and a respondent from a regional body, said children should have the same opportunity to be heard as adults as a matter of principle. For example, a member of the public said that children are "just as entitled to excellence in service as adults." A respondent from a national body expressed this in terms that are more concrete: "The UNCRC (UN Convention on the Rights of the Child) means that young people have a right to participate in decisions about their own care including healthcare and the right to express their views, so the survey provides one means of fulfilling that right."

A range of respondents in all roles acknowledged the importance of enabling children and their carers to provide feedback. A respondent from a medical professional body commented that it was important to survey children and young people as "…for many respondents it may be their first encounter with secondary care. Their experience is likely to have a profound effect on their attitudes toward secondary care in the future."

A large number of other respondents, in all roles, said they would benefit by receiving better information about children and young people's services. For example, it was mainly service providers who said it would provide more regular data. Members of the public also said parents and carers would benefit from understanding their children's experience of services. A few respondents from regional and national bodies highlighted that there was currently little information from this group, which meant information from this survey was greatly needed.

Monitoring and improving services

Benefits

A number of service providers said that the proposed survey would enable benchmarking and would monitor the progress of improvements. Other service providers explained that they would be able to compare their services with those in other organisations, make comparisons over time and compare children's and adult services within their organisation. A service provider noted that they would be able to triangulate data from the children's survey with their data from internal patient experience programmes; and a respondent from a regional body noted that they could obtain information on the transition between children and adult services.

The information would "help target resources where they are needed most and reduce misuse and squandering of public funds" (service provider).

Challenges

A number of service providers said that costs would increase and some said there would be "more data to analyse" and "more data sampling and survey coordination". One service provider pointed out the context of "already limited resources" and another suggested the new survey be run every three years not every two, for this reason.

Survey design, administration and costs

Benefits

There was little commentary on the benefits in relation to this. Although one provider stated that if the survey does become part of the regular programme, it "would result in a clear timetable rather than Trusts opting in and out" (service provider).

Challenges

The overall challenge mentioned by a respondent from a national body, a medical professional organisation and a service provider, was that children's services are 'complex' to measure. Respondents suggested a range of different services that should be included in the survey, and said this would present challenges for 'disaggregating the data' when reporting on multiple different services within one survey.

Many respondents, predominantly service providers, cited 'response rates' as a challenge – ensuring that a sufficiently high proportion of children respond to the survey. A service provider implied that an additional survey to administer would cause 'survey fatigue' for themselves, as the administrators.

A few other respondents commented on the method of completion. Two service providers suggested providing online questionnaires but a respondent from a research organisation explained that it would be a "significant problem" to distribute a survey questionnaire by post and then persuade recipients to "shift modes" by manually typing in a web address to complete a survey online. They therefore suggested CQC consider explores the possibility of trusts collecting email addresses of children and their families.

Q4: Pilot a new survey for community health services

Listening to people who use community health services

Benefits

Respondents from all types of organisations (charities, service providers, national and regional bodies) commented on the "dearth of data in this area" and a few said that this data is vital and desperately needed. A member of the public and a service provider noted that this need was due to the increasing use of community

services by an ageing population. The move towards integrated approaches to healthcare (see next section) has also created a need for this data. Also, two service providers said that community services "should be subject to the same scrutiny as secondary care".

It was predominantly members of the public who acknowledged the potential opportunity to have their say. For example, someone caring for a relative in the community said, "…we feel neglected and isolated so maybe we could have a channel open for communication."

Many respondents in all roles (service providers, respondents from regional and national bodies, charities and members of the public) commented that the proposed survey would provide new data. Respondents from a range of organisations said that the data would be better, for example, more "in depth" (service provider) and cover a wider range of services (regional body and service provider).

Service providers commented that the data would enable them to 'benchmark' themselves with other trusts. A common issue among respondents from various types of organisations was the ability to understand the whole system of care (see next section).

Challenges

Two respondents cited challenges with interpreting the feedback. A member of the public said it would be difficult to interpret the results applicable to their area, and a respondent from a national body said it would be difficult to draw conclusions due to the varied population that use community services.

Understanding the whole care pathway

Benefits

A respondent from a national body and a number of service providers mentioned the policy shift towards 'devolution' of services away from acute care and into the community setting, as a rationale for obtaining more information about community services in the proposed survey.

Others (mainly from national bodies and service providers) explained that knowledge of whole care pathways was important to understand how community-based care might be improved to reduce the number of people needing hospital-based care, which would relieve the pressure on hospitals. Other service providers explained that community services "affect the journey into the trust" but also out of the trust, citing the potential insight they would gain into 'post-acute care'.

Respondents from a national body and a medical professional body cited the need to understand the links between all community services, not just between primary and secondary care. A service provider noted that understanding all children's health services in the community (for example, school nursing, health visiting and children's community nursing) would help communication between them, about safeguarding for example.

Respondents commented that this data might help to improve services, for example "prevent wasted use of hospital services" (service provider). A respondent from a national body believed the survey would "bring about more relevance to the direction of deployment of resources".

Challenges

Due to the joined-up nature of community care, the responsibilities of each provider need to be ascertained to identify who owns the recommendations and actions. A respondent from a national body explained that an episode of care may involve both health services and services run by the local authority so the boundary should be defined. A research organisation and a service provider said, "it is necessary to clearly attribute feedback to each service type and be able to filter the data."

These services would also need to share data because they need to capture "the pathway of care", by mapping with data from other surveys (national body). This could pose a further problem.

Survey design, administration and costs

Benefits

A service provider believed that a national survey would mean the "sending out of surveys and collection of data would be coordinated centrally… [saving] a significant amount of admin time". Another said it would also be "consistent with the model used for acute services".

Challenges

Respondents were unsure how community services would be defined. Service providers cited the problem of a "vast array" of services the proposed survey could cover, and the need for a clear definition of which services to include.

Service providers, respondents from research organisations and national bodies also cited logistical issues of designing a sample large enough to ensure sufficient responses for each of the many services, including a lack of reliable patient records and the problems of surveying people in residential care. Locating the particular data for analysis will be very time consuming, and without assistance from a central data service, "analysis would be impossible" (research organisation).

Many respondents, mainly service providers, cited the increased costs of an additional survey as a challenge. A respondent from a research organisation said that if there was a choice between introducing this survey or maintaining the outpatients survey, "a revision of the outpatients survey may prove a safer alternative investment."

Respondents thought that people may not understand what the survey involves and which components they should report. Furthermore, many in the community are supported by multi-agency teams, which could affect clarity of responses. A respondent from a research organisation noted "the impaired cognitive abilities of many patients" as a challenge to obtaining reliable feedback.

Q5: Continue with an annual adult inpatient survey for acute trusts and an annual community mental health survey for mental health trusts

Monitoring and improving services

Benefits

Some respondents described the benefits and importance of these surveys, but it was not clear if this was related to the issue of survey *frequency*. For example, a respondent from a charity said, "We could find out and learn from good practice". A number of service providers (and two members of the public) referred to the data being "regular", which was useful for services to be able to monitor performance (see below).

Respondents in all roles, including service providers, respondents from regional and national bodies and a few members of the public said it would enable them to identify trends and changes over time. A service provider mentioned that annual surveys mean they could "triangulate" the data with data they receive from the FFT. The other aspect of monitoring commonly mentioned by these respondents was the ability to compare themselves with other trusts nationally or locally. For example, a service provider said, "If the results were not annual we would need to develop a local equivalent survey which would not have the added benefit of benchmarking with peers."

The annual survey will "ensure improvements are made in a realistic timeframe" (service provider). A member of the public commented that using out of date information causes "delays in incorporating up to date procedures" and that it "allows persons opposed to change the chance to create a delaying situation."

Annual surveys are needed "to plan for the forthcoming year" (service provider) and "to inform commissioning decisions" (regional body). The annual frequency was good as it was "a way to regularly monitor change at a pace that would allow service change to be implemented and felt" (national body).

Many respondents in all roles said the data they received from these surveys was "… up to date". A member of the public said "Any longer and outcomes shown may be proved useless as things will have moved on by events."

Challenges

Many respondents (service providers) said that it was difficult to implement changes based on feedback from the [annual] surveys. This is because there was insufficient time after receiving the findings to design and implement changes, before the next survey begins. A number of these respondents explicitly suggested that for this reason, the frequency should be reduced. For example, "If the surveys were less often then time and resources could be put into making improvements" (service provider).

A service provider said it was "sometimes more difficult to evidence change" on an annual basis and "If the survey was bi annual [sic] [meaning every two years: biennial] this would enable improvement actions to become embedded and hopefully evidence clear impact in subsequent survey findings." A respondent from a national body also commented that "results don't change much year on year."

A service provider said "… it may make more sense therefore to hold the urgent care survey annually rather than the inpatient survey." Another service provider suggested alternating the inpatient with the outpatient survey, so each is conducted every two years.

Survey design and administration

Benefits

Three service providers, a respondent from a regional body and a national body cited the benefit of consistency. For example, "Our clinical teams are used to the annual adult inpatient survey. They always receive the survey results during the summer ready to prepare their action plans by the autumn" (service provider).

Challenges

Some challenges were not obviously related to the issue of frequency of the surveys but other administrative or design issues. For example, "The current survey is extremely lengthy" (service provider).

A few service providers explained that 'survey fatigue' and 'response rates' were a challenge. Another service provider noted that the annual surveys meant they had three surveys in one year, so they should be "spaced throughout the year and not all within the same few months."

The other challenge for service providers, members of the public and national bodies was the increased costs and workload. A respondent from a national body said that "annual surveys are poor value for money given that the results generally don't change much year on year."

Feedback on services

Benefits

Many respondents from charities, national bodies, regional bodies and service providers said the data from the surveys would be more 'frequent', 'up to date', 'timely', 'useable' and 'relevant' and therefore more 'meaningful'. This is an implicit reference to the increased frequency of the surveys.

This would help with identifying and tracking changes and improvements. For example, "More frequent information and more meaningful trends. Particularly critical when major changes are often introduced at less than three yearly intervals." (service provider).

Challenges

Many respondents from regional bodies, national bodies, a charity, a commissioning body, service providers and a few members of the public said that a two-year cycle was too infrequent. For example: "over such a long cycle staff and policies change" (regional body). A respondent from a national body asserted that the CCG Improvement and Assessment Framework for assessing and supporting CCG performance was undertaken annually. Therefore, the maternity survey should be run once a year "in order to allow the health system to meet its mandated responsibility to support CCGs to improve and have comparable year on year data."

A smaller number of respondents appeared to support a frequency longer than two years. A respondent from a research organisation said they doubted that responses would vary over the additional year to make much of a difference to data users. Two service providers said they needed time to implement changes, suggesting that the increased frequency of surveys would compromise this.

Survey costs, resources and workload

Benefits

A few service providers said that the surveys would be "easier to plan" due to "a clear consistent approach in terms of a timetable". A respondent from a research organisation also said that "greater foreknowledge of the future programme should boost [staff] engagement with [it], whereas in the past a lack of advance information about planned surveys has sometimes prompted anger and resentment from providers."

Challenges

A single service provider cited a challenge relating to survey planning: "There would need to be some communication with other commissioners of national surveys to ensure that any additional surveys are carefully scheduled in order to balance workload for Trusts."

Many respondents, mostly service providers, said that the increase in survey frequency would lead to increased costs in money or staff time and workload. One respondent, from a national body, recognised the increased costs for trusts but thought "this is fair and proportionate" and one service provider thought the benefit would be worth the additional costs. Another cited the problem of costs in terms of budgeting, if the survey programme differed each year.

Three service providers said that the increased number of surveys could cause 'survey fatigue' and negatively affect response rates.

Q7: Implement new approaches to improve response rates across all surveys

The feedback on this question is presented below in terms of the barriers that could affect response to the patient surveys, and the solutions proposed by those responding to the consultation. Further issues are also outlined, based on the consultation feedback.

Some responses to this question appeared to relate to general issues with the survey programme and not the response rate specifically. These are included in the section on question 9. Conversely, some comments on question 9 referred to response rates and are therefore incorporated here.

Respondents from national bodies and research organisations commented on the process of reviewing response rates, and the issues to consider when planning how to improve them. A respondent from a national body suggested that CQC consult specialist organisations (for example, Mind/Rethink) to understand the barriers to response among specific patient populations. Respondents from two other national bodies suggested that the public, especially people who did not respond to previous surveys, should be consulted to understand the reasons for this. One suggested that "CQC and the survey co-ordination centre could support trusts to pilot their own interventions locally…that could then be shared and spread."

A respondent from a national body thought that "trusts can have the biggest impact on the success of the individual surveys". A member of the public also commented "Lack of enthusiasm from staff as so many of them can only see the 'complaint' side of patients being involved in surveys rather than the 'opportunity to learn and improve' side. Staff dismissive of patients responses." A service

provider also suggested that the "emphasis needs to change to increase public and staff engagement with gaining feedback and utilising it".

The four main barriers that prevent people responding to the survey are discussed below, followed by the barriers that arise from aspects of the survey process itself.

Too many surveys ('survey fatigue')

Survey fatigue was frequently mentioned, mainly by service providers: "patients don't want the constant disturbance of filling in forms and completing surveys all the time. Especially if they visit on a regular basis" (service provider). Respondents from regional bodies, a national body, a research organisation and members of the public, also mentioned that there were "too many surveys". Respondents listed all the other healthcare surveys as well as the NHS patient surveys, but a few service providers singled out the Friends and Family Test as the cause of survey fatigue. Service providers also pointed out the increasing number of requests for feedback from other, non-healthcare organisations. For example, "Every business and service industry is now seeking feedback from customers".

Respondents also highlighted survey fatigue as an issue to consider in the consultation proposals.

Solutions

A service provider suggested working together to plan the surveys: "A joined up approach is vital, ensuring NHS providers and commissioners are not all asking the same questions to the same populations." A respondent from a national body also made a similar suggestion, and mentioned that the NHS England National Insight Team is currently looking at the potential for broadening the FFT. A service provider suggested stopping the FFT, because "some patients do not complete the national survey questionnaires as they feel they have already given their views."

Lack of motivation

Members of the public and service providers said that due to 'cynicism', people believe that the NHS will continue with plans regardless of their feedback. Others cited patient apathy and a lack of interest, perhaps where "unwell patients do not feel up to completing surveys unless they have had a bad time" (member of the public). Also, a lack of time puts people off from responding to surveys.

Solutions

Many respondents, mainly service providers, suggested that patients receive some incentive to complete a survey, for example, a £5 voucher or a pledge to donate to charity (such as the BME Cancer Network). One service provider pointed out that an incentive had been used in the 2016 National Audit of Dementia in both the staff and carer surveys.

Uncertainty about the use/importance of responding to the surveys

A large number of respondents in all roles suggested that some people do not understand what the survey programme is for, why they need to complete a questionnaire and why it is important to do so. People are also unsure of whether the information would be used. A member of the public said, "I would not want to complete a questionnaire…if I felt my comments would be ignored". A few service providers said the delay in publishing the findings and the short time they had to act on them discouraged responses because people would think the findings were out of date by the time any changes were implemented.

People are uncertain about the practical use of the information, which a respondent from a national body described as a "lack of connection with how the surveys drive improvement in care." People are not aware of "what it [the surveys programme] means for them as NHS users" (service provider).

Solutions

Respondents in all roles, including from commissioning bodies and research bodies, service providers and members of the public, said there should be wider publicity about the survey programme. This included about the importance of participating and how trusts use the surveys to improve services.

Service providers, respondents from research organisations and members of the public suggested national and local media publicity before each survey. Suggestions included TV/radio, online through social media and text message alerts. Respondents from a charity, regional bodies and members of the public suggested that Healthwatch and other third sector and voluntary organisations could help to publicise the surveys, for example through their email newsletters. A respondent from a commissioning body suggested "patients and lay members" could also help promote the survey. Respondents from regional and national bodies and two service providers suggested advertising through patient participation groups (PPGs) and hospital trusts. It should be noted that surveys are publicised locally by trusts through a range of means including flyers and posters.

Service providers and respondents from national bodies suggested various publicity materials could be supplied to service providers – posters, leaflets with a QR code (to scan using a mobile device, to reach a particular website/page), and "videos (for trusts to put on their websites and in-house TV screens)."

A number of respondents from national bodies and service providers said trusts should include examples of service improvements in the covering letter sent with the questionnaires. A number of service providers and members of the public suggested a campaign entitled "You said - we did". A national body suggested that CQC should "develop improvement case studies illustrating how results can be used". Another respondent from a national body suggested studying how the inpatient survey data is being used for improvement alongside local surveys.

Members of the public and service providers suggested that "people need to see feedback of the consultations they contribute to [so they] know their views do not

just disappear into a governmental black hole somewhere!" (member of the public). A respondent from a charity suggested "providing results to respondents and closing the loop on patient feedback. This could help address scepticism about the likelihood of feedback being used to drive change." A service provider suggested respondents to the survey "be invited to be part of a working group to implement changes". A member of the public called for "more face to face and feedback sessions."

A service provider suggested publishing the results sooner so the results were less likely to be out of date, and a respondent from a charity suggested emailing the results to respondents to the survey.

Mistrust and confidentiality

A few respondents (from regional bodies, service providers and members of the public) said that people might be concerned about the confidentiality of the surveys. They would be concerned that if any of their negative comments were traced back to them, it could adversely affect their care. This means they might instead choose not to respond. Some members of the public suggested that they would not want to respond to the survey anyway – not through fear of confidentiality issues but because they would not want "to bite the hand that feeds them".

Solutions

Respondents did not provide any suggestions explicitly for improving confidentiality or improving trust. However, a service provider suggested that having no personal relationship with the person asking the questions was a barrier. A member of the public suggested personally enrolling individuals in the survey. The implication of these comments is that people responding to the survey might be more trusting if they had a personal relationship with the person asking for the survey.

Improving response rates

Respondents from a national body and a research organisation and one service provider mentioned the need to consider the cost of interventions. These are interpreted as meaning actions to improve response rates, such as offering alternative formats of questionnaires, or sending reminders, facilitating face-to-face interviews for those who cannot post a survey, or the cost of redesigning the questionnaires. These respondents said that these interventions should "offer good value for money, in terms of both overall expenditure and the unit cost of response for organisations participating in the survey" (research organisation).

The respondent from a research organisation also said that actions to improve response rates should be assessed to ensure they have not adversely affected how representative the survey is – if the response rate only improves among certain patient groups and not others, this introduces bias into the data.

Suggestions to improve response rates relating to detailed aspects of the surveys are discussed below, in the order they would be carried out in the process.

Sampling

There was a suggestion to "use the electronic appointment system in some clinics and GP practices as a survey tool" though there was no explanation of how this would affect response rates. Another suggestion, by a service provider, was for a smaller number of questions in the questionnaire to be "split over a larger cohort of patients." A respondent from a research organisation suggested "oversampling" certain groups of people who are less likely to respond, to ensure that a sufficient number of responses is still obtained when response rates are low. More than one service provider also suggested increasing sample sizes.

Survey timing

Two respondents suggested that the timing of the survey could affect response rates. A service provider suggested people should be surveyed "closer to the clinical episode (1-2 months after)" as people "forget to send in/do online later" and a respondent from a medical professional body suggested surveys are carried out "at the point of treatment rather than be sent out later as questionnaires". This latter comment implies that response rates to postal questionnaires would be lower. This may be because questionnaires get lost in the post (either being sent out or returned), or respondents might feel less motivated or capable of completing a questionnaire without any personal contact with the person asking the questions (see earlier section).

Initial contact

Service providers suggested that letters should come from medical staff rather than management, and freepost envelopes are provided for the return of questionnaires. It should be noted that freepost envelopes are already provided.

A respondent from a national body suggested that cover letters be reviewed for tone and content. They cited the findings from a pilot of the NHS staff survey and GP patient survey, where this "resulted in positive changes to [the] response rate." A respondent from a research organisation supported this.

Paper versus 'electronic' surveys

Most respondents in all roles said that there should be a choice of format for the surveys. Many of these respondents specifically suggested that there should be 'online' options. Suggestions for these included a link on the trust's webpage or on social media, QR codes on tablets, an 'app' that is mobile compatible, or surveys sent by email. A respondent from a national body claimed that using online surveys had saved 20% of their programme costs.

In addition to this, a few respondents (from a national body, charity and one service provider) noted that email addresses should be 'mandatory' information collected by trusts to facilitate sending out electronic surveys.

However, a respondent from a commissioning body asserted online response rates are "low across the board". A respondent from a charity agreed with this, but still supported online surveys for their client group who "use technology as a faster way to engage". (A respondent from a national body referred to earlier feedback on the children's survey, which indicated that paper surveys were unsuitable for this group).

Nobody explicitly suggested that paper surveys should be discontinued. A service provider suggested they should be available "in walk in centres, libraries and church halls". A member of the public suggested "as many outlets as possible", for example A&E surveys could be held in GP surgeries.

However, a respondent from a research organisation noted that response rates could be different for each mode. If an individual changes their mode of response over time, or if people respond through different modes within the same survey, the results may not be comparable. They also recommended that people should not be sent a questionnaire in hard copy and then relied on to return one electronically, as the change in 'mode' for respondents makes them less likely to respond.

After questionnaires are issued

Service providers and a respondent from a commissioning body mentioned text message reminders as a possibility to consider, though a service provider pointed out the problems with consent if mobile numbers are only given for purposes of clinic appointment reminders, not 'research correspondence'.

Respondents in all roles suggested that volunteers or 'independent advocates' (such as students, patients or carer groups) could help people such as children, older people, people in poor physical or mental health, or those with a learning disability to complete questionnaires.

The questionnaire

Respondents mentioned aspects of the questionnaire itself as a barrier to responding to the survey. Many respondents (mainly service providers but also from research organisations, national and regional bodies and charities) said the questionnaire is too long, or there are too many questions.

Others among those respondent groups said that the style and format of the questionnaire was off-putting to respondents with a learning disability, for example. The most common issues were the language used and the need for improved translation services.

Solutions

Many respondents, mainly service providers, said the survey should be shortened to include fewer and more simple questions, such as more 'yes/no' and multiple choice questions. Many respondents in all roles also commented on improving the format of the questionnaire. More specifically, supplying versions in different languages (research organisation and a regional body) and making them more accessible to those with a physical or a learning disability (British Sign Language, easy read formats, braille and audio versions).

A respondent from a national body suggested reviewing the guidance given to patients on completing the questionnaire. One suggestion was to provide shorter surveys to frequent visitors and allow them to only complete what is applicable to them.

Publication of results

The results of the survey should be published more promptly. Some suggested methods for this, such as providing an electronic postcard or something for them to access the results when they are published, or an offer to email them the results. Another suggestion was to provide the summary results by post and not just online.

Q8: Feedback on the accessibility and usefulness of the current reporting, and the aspects that could be improved

Reporting

A few respondents (service providers, and respondents from a national body and two regional bodies) said that there should be a summary of key points, or implied this when they said that there was too much information. A service provider suggested an "exception report" at the beginning (this is a report highlighting differences or changes, or new information, and therefore contains less data than a report of all findings).

A service provider asked for reports to include an explanation of how the data "feeds into CQC operations". A respondent from a research organisation said that more detailed guidance for analysis was required. A respondent from a charity suggested linking the results of the inpatient survey more closely to measures of patient safety, to better 'drive improvement'. A respondent from a research organisation made a similar suggestion, to link patient experience reported in the surveys with patient-level hospital data on safety and effectiveness. A respondent from a charity asked the question "how will the data reflect 'place based' services in future?"

Members of the public, service providers, and respondents from regional bodies, a charity and a national body all said that the reports should include information about actions taken (or planned) and what difference the results have made. A list of currently identified trust leads should be "readily available for networking and shared learning" (service provider). A member of the public and a service provider suggested that reports of good practice should also include the contact details of someone to help share it. Another suggested publishing details of the costs and benefits of actions described. A service provider suggested a website dedicated to sharing best practice.

A service provider said they wanted results to be weighted in terms of their relative importance. A respondent from a research organisation commented that "arguably, it [weighting] introduces new bias into the data", and a service provider said that reports should include an explanation of weighting.

A service provider asked for thematic coding of comments to be provided as standard and not at additional cost.

Reporting scores

Respondents commented on how providers' performance was reported - the design of the 'scoring' system and the presentation of comparative scores for other providers. Respondents had mixed views on the system of reporting 'the same as', 'better than' and 'worse than' and presenting scores out of 10. A small number of service providers commented that this was not helpful and a respondent from a research organisation said, "Stop using scores and instead report 'percentage of patients who said x', which is much easier to understand."

A service provider and a respondent from a national body questioned the use of only three categories of scoring. They said that each category was too broad to be able to accurately distinguish differences in performance between 'well and adequate'. Another service provider and a respondent from a research organisation said that the Red, Amber, Green colour coding was confusing as for some issues, green represented an improvement and sometimes a deterioration.

A few service providers said that it would be useful to present the top national score against which they could compare themselves. A respondent from a national body suggested developing a national benchmark for each question. Many other respondents commented on the type of data they wanted to be able to make comparisons (see below).

Presentation of data for benchmarking/comparison

There were numerous comments from service providers, respondents from national and regional bodies, and the Department of Health, about how the data should be broken down for purposes of making comparisons.

It was mostly service providers who wanted the data broken down by trust level; service area/site; specialty (for example medical and surgical); and wards. Respondents from a national body, a charity and regional bodies also mentioned this, one of which explained that if trusts merge, the data for the merged trust needs to be broken down to be able to compare the merged parts. Two respondents from national bodies said they would support publishing the data at CCG level. Members of the public said data should be "locality specific" though one specified that such comparisons should only be for similar services such as acute trusts.

Respondents from national bodies, a charity and service providers suggested disaggregation by different demographic factors (age, ethnicity). Respondents from regional bodies, a national body, a research organisation and service providers said that data should be provided to illustrate long term trends (up to five years) rather than only 'year-on-year' data.

A few service providers and a respondent from a regional body said that they wanted to be able to compare results with previous surveys and that changes to survey methods in different survey years could hinder this.

A respondent from a regional body suggested asking more consistent questions across the pathway, for example about antenatal and postnatal care in the maternity survey. This would make it easier to compare parts of the same service.

Results format

A few service providers described the current presentation as good.

A respondent from a national body recommended commissioning a review of alternative presentation formats. A respondent from a different national body said they would "like to explore how CQC reports and analysis could be extended to serve multiple purposes."

The most common issue raised in the feedback was that results were difficult to understand or interpret and need more graphical presentation. A few members of the public said the reports should be simpler, for example containing less jargon, and be more "visually attractive, appealing and engaging." However, it was mainly service providers who explained that the data was difficult to interpret and needed to be more 'user friendly'.

Again, it was service providers who said that the diagrams were not clear. Other service providers (and some members of the public and respondents from two national bodies) said that there should be more 'infographics', pie charts and graphs and 'visuals'.

A respondent from a national body said that they "would find it useful to have an annual report covering all surveys that year, with data presented to add further value form the totality of information." Some service providers also said they would prefer to receive "one set of data" and one suggested a single organisation responsible for publishing benchmarking data, to reduce confusion. A service provider said data should be published in such a way that it can be compared with data from other sources such as the FFT, complaints data etc.

Accessing data

Respondents from regional bodies and a commissioning body said that it was difficult to know which website to use to find the information and difficult to view data across multiple organisations. They needed to close one page before opening another, and had to apply separately by email for year-on-year data. A respondent from a commissioning body recommended having a summary page for each organisation. Members of the public also said data should be "easier to find". More than one service provider and a respondent from a regional body said they disliked files in PDF format, as these do not allow use of the tables in reports and presentations.

Respondents (mainly from national bodies and research organisations, and a few service providers) said they would like to access more of the raw data themselves. They suggested more interactive formats, such as software and 'automated tools' that allow them to conduct their own bespoke analysis. A service provider suggested placing results on an app for individuals to be able "to see what impact their answers have".

Mainly service providers said they wanted results more quickly, "at the earliest opportunity". More than one said that they would like pre-publication access, to allow them more time for detailed analysis and to formulate their response to the findings.

A respondent from a research organisation suggested offering the raw data to universities for their own analysis and increasing the use of the inpatient survey data for research, for example "by releasing separate versions of the dataset with different access and authorisation requirements" to avoid breaching data confidentiality.

A service provider suggested allowing the option for respondents to the survey to provide their contact details, to be contacted if further clarification would be useful.

Dissemination of results

Audience

Respondents from a regional body, a national body, a commissioning body and a medical professional body all said that there should be flexibility in the way reports are written for different audiences. A respondent from a research organisation suggested that the focus of improvements should be on reporting for the benefit of patients, service users, their family and carers.

A service provider suggested data should be sent to Healthwatch England, the Government and the media. A member of the public suggested sending it to the public, commissioners, councillors and MPs. A respondent from a medical professional body suggested that the data be presented at professional conferences.

There was some evidence from the responses that the data had not reached people. A service provider commented, "Have never seen this data". Respondents provided various suggestions for ways of doing this.

Method

Comments about this were mostly from members of the public and respondents from national bodies. Members of the public said there should be 'more publicity' and suggested this could be on social media, posters in services/on wards, leaflet drops and local press. Another suggested public meetings to discuss the findings. Service providers suggested posters. Respondents from national bodies suggested Twitter chats, podcasts and face-to-face events.

More than one service provider recommended follow-up workshops run by their survey contractor as useful to help them understand the results. A respondent from a national body suggested information is needed about triangulating the survey results with other patient experience data. A respondent from a different national body suggested linking with NHS Improvement to share the results and identify improvements.

Timeliness of result availability

There was a strongly held and common view among respondents, mostly service providers, that results should be published sooner. "The final reports from the CQC are months and months after the fieldwork." This lag meant the results would be 'less relevant'. This complements other comments about needing earlier access to the findings, preferably pre-publication (see previous section). A few service providers suggested that this could be speeded up by shortening the deadline for respondents to the survey to return their questionnaires.

Q9: Any further suggestions about how we can help to make the most of the survey data in others' work, so they can gain more value from the surveys

Many responses to this question were related to questions 7 (response rates) and 8 (the use of survey data), so they have been summarised within those sections.

Therefore, the responses summarised here are all other observations about the surveys programme that have not already been mentioned in the previous sections.

The Patient Survey Programme overall

A respondent from a national body offered to facilitate collaboration between the Department of Health, CQC and other stakeholders, for example, to help to align the survey data for use in the General Medical Council's process of appraisals for doctors. This would also help with understanding how all surveys complement each other, such as the fit between the FFT with the national surveys. A service provider said that the National Cancer Experience Survey should be taken into account in the survey planning. A respondent from a charity said a review was needed as questions in different surveys may be framed in different ways making comparisons across surveys difficult.

Other respondents suggested a targeted approach with the surveys. For example, respondents from a charity and a national body suggested focusing on measuring experiences in relation to a particular condition rather than a specific service. A respondent from a medical professional body suggested that new methods of obtaining feedback are required "that span organisational boundaries."

More than one service provider suggested obtaining feedback 'in real time'. One of these said, "an annual survey is old school." Other service providers suggested that there were more 'exciting' ways to gather feedback, there were "too many surveys" and there should be "a mix of methodologies". A respondent from a national body also commented that surveys based on outcomes of specific care services misses out the experiences of the transitions between

different services and of those people who have difficulty accessing the services in the first place.

A respondent from a national body said it was important that the surveys were designed to measure the differences between mental and physical health services. Other respondents cited specific areas which they felt needed more attention from a survey programme, for example, the views of carers (a national body and a regional body), day care services (service provider), the reason for A&E admission (national body), Improving Access to Psychological Therapies (IAPT) services within mental health care (national body) and "issues re housing and hope" for patients (service provider). A respondent from a charity suggested extending the maternity survey to cover people whose babies had died before, during or soon after birth, while a respondent from a national body suggested comparing experiences by the setting in which people gave birth.

Respondents from a charity, research organisations and a service provider said that data was needed at "a more granular level" and therefore that the surveys should be redesigned so that this is possible. For example, increased sample sizes (which would inevitably increase survey costs) and all surveys being UK-wide to enable comparisons of services in the devolved administrations. A respondent from a national body suggested a review of the method of analysis, so that "comparative performance on patient survey data is measured reliably and in a way that adjusts adequately for differences in case-mix etc".

A respondent from a national body suggested that there should be clarity on what the survey programme tells people about how their survey data is used, for ethical reasons, as currently it is used for more purposes than respondents are perhaps aware of.

Some respondents mentioned the issue of impartiality. The surveys are run independently from the providers whose services are being surveyed, to ensure the results are as objective and unbiased as possible, but some respondents questioned whether the input from the providers in the process, such as selecting lists of patients to sample, may introduce bias. A respondent from a research organisation and a member of the public said that trusts should not be permitted to draw their own samples to prevent "cheating, even unconscious cheating" and in case they "only poll patients with positive experiences."

A member of the public raised the issue that the timing of the surveys might also generate biased responses: "unwell patients do not feel up to completing surveys unless they have had a bad time."

A service provider said maternity surveys should be given to people while at the hospital. The timing of the maternity survey would avoid the risk of surveying patients whose babies may have died since birth.

Glossary of terms

Term	Definition	Source
Administration (of the questionnaire)	The method of obtaining responses to survey questionnaires.	
Benchmarking	Standards, or a set of standards, used as a reference for evaluating performance or level of quality.	http://www.businessdictionary.com/definition/benchmark.html
Clinical commissioning groups (CCGs)	Clinically-led statutory NHS bodies responsible for the planning and commissioning of health care services for their local area.	http://www.nhscc.org/ccgs/
Exception report	A type of summary report that identifies any events that are outside the scope of what is considered a normal range.	www.yourdictionary.com
Friends and Family Test (FFT)	Short questionnaire given to patients immediately after receiving healthcare services, centred on the question '"How likely are you to recommend our service to friends and family if they needed similar care or treatment?"	http://www.nhs.uk/NHSEngland/AboutNHSservices/Pages/nhs-friends-and-family-test.aspx
Improving Access to Psychological Therapies (IAPT)	A national programme to increase the availability of 'talking therapies' on the NHS. Primarily for people who have mild to moderate mental health difficulties, such as depression, anxiety etc.	http://www.londonhp.nhs.uk/services/mental-health/improving-access-to-psychological-therapies-iapt/
Member of the public	Ordinary people, especially all the people who are not members of a particular organisation or who do not have any special type of knowledge. In this report they may be or have been patients or service users.	http://dictionary.cambridge.org/dictionary/english/general-public
Mind/Rethink	Mental health charities.	http://www.mind.org.uk/about-us/what-we-do/
Mode	The method of giving out and receiving back survey questionnaires – for example, telephone, online, email or by post.	http://www.dism.ssri.duke.edu/survey_mode.php
Quick response (QR) code	A machine-readable optical label containing information about an item to which it is attached. For example a code on a letter about the survey that links to a webpage containing the questionnaire.	https://en.wikipedia.org/wiki/QR_code

Patient and Public Involvement (PPI)	PPI In research is an initiative to include patients in research so that research is done by them or with them, rather than to, for or about them.	http://www.healthtalk.org/peoples-experiences/improving-health-care/patient-and-public-involvement-research/what-patient-and-public-involvement-and-why-it-important
Reliability	The extent to which an experiment, test, or measuring procedure (e.g. a question in a questionnaire) yields the same results on repeated trials (or would do if the same question was asked again).	http://www.merriam-webster.com/dictionary/reliability
Representative	Typical of a particular group of people or of a particular thing.	http://www.merriam-webster.com/dictionary/representative
Respondent	Person who submitted a response. In this context someone who responded to the patient survey consultation (on their own behalf or on behalf of their organisation or colleagues).	
Response rate	The number of people who answered the survey divided by the number of people in the sample.	https://en.wikipedia.org/wiki/Response_rate_(survey)
Sample size	How many people were chosen for the survey (respondents and non-responders).	https://explorable.com/sample-size
Sampling	The act, process, or technique of selecting a suitable sample.	http://www.merriam-webster.com/dictionary/sampling
Self-administered (questionnaire)	A type of questionnaire that the respondent completes on their own.	https://medanth.wikispaces.com/Self-administered+Questionnaire
Survey fatigue	When someone completes a survey and is then inundated with invitations to complete other surveys, they feel tired or 'fatigued' about taking surveys.	http://www.zarca.com/Online-Survey-Resource/Survey-Best-Practices/responsible-online-survey-administrator/survey-fatigue.html
Survey 'tool'	A process or thing used as part of the survey, for example apps, questionnaires or analysis software.	
Triangulation	A "method of cross-checking data from multiple sources to search for regularities in the research data."	O'Donoghue, T, Punch K (2003), *Qualitative Educational Research in Action: Doing and Reflecting.* Routledge. p.78.
Weighting	Rather than each variable in the data (the responses to a question from certain groups) contributing equally to the final result, some data are adjusted to contribute more than others.	https://en.wikipedia.org/wiki/Weighting

Acronym	Meaning
A&E	Accident and emergency
BME	Black and minority ethnic
CAMHS	Child and adolescent mental health services
CCG	Clinical commissioning group
CPES	Cancer Patient Experience Survey
CYP	Children and young people
FFT	Friends and Family Test
GMC	General Medical Council
IAPT	Improving Access to Psychological Therapies
IP	Inpatient
IPS	Inpatient survey
LA	Local authority
MSK	Musculoskeletal (healthcare for people with muscle or joint problems)
OP	Outpatient
OPS	Outpatient survey
OPES	Overall Patient Experience Scores
PPG	Patient participation group
PPI	Patient and Public Involvement
QR	Quick Response (Code)
UNCRC	United Nations Convention on the Rights of the Child

Further information

The full consultation document with more detail on the proposals and our request for feedback is available on our website:

www.cqc.org.uk/surveyconsultation

We have also published CQC's response to the consultation, which summarises the feedback and states how CQC will go forward with the changes to the survey programme. This includes a list of organisations that responded to the consultation.

Our website also has all the information on the NHS Patient Survey Programme, including results from previous surveys and the programme of current and forthcoming surveys:

www.cqc.org.uk/content/surveys

Information on how the surveys are designed and carried out is available from the Patient Survey Co-ordination Centre's website:

www.nhssurveys.org/

Further questions

This report was produced by CQC's Survey team and Qualitative Analysis team. If you would like to contact the team directly please contact Paul Williamson, User Voice Development Manager, Patient.Survey@cqc.org.uk.

Feedback

We welcome all feedback about the responses to this consultation 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 we could improve this publication, please contact Paul Williamson, User Voice Development Manager, at Patient.Survey@cqc.org.uk.