

# **NHS Patient Survey Programme**

# **Quality Statement**

**November 2015**

## About this document

This document outlines how quality is preserved within the NHS Patient Survey Programme. Survey results can be used to facilitate improvements in patient care, providing a snapshot of how well patients are being cared for at a given point in time. It is important that the data is credible, fit-for-purpose, and that others have confidence in our work. Here we set out how quality is maintained throughout the survey process, including development, implementation, analysis and reporting.

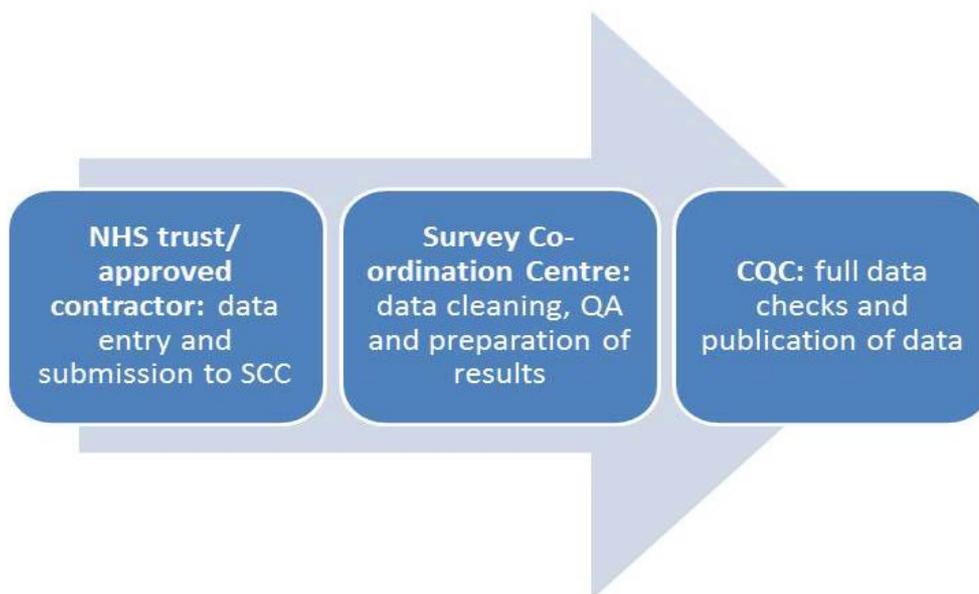
This document accompanies a portfolio of supporting materials about the survey programme. These can be viewed at: [www.cqc.org.uk/surveys](http://www.cqc.org.uk/surveys)

## Introduction

This statement outlines the Care Quality Commission's (CQC) Quality Assurance (QA) Framework for the NHS patient survey programme, referring to relevant principles from the European Statistical System Code of Practices as contained within their Quality Assurance framework ([ESS QAF](#)).

The NHS patient survey programme (NPSP) is overseen by the Intelligence Directorate at CQC. The surveys are designed to collect feedback on the experiences of people using a range of NHS healthcare services, and are implemented by NHS trusts. Currently, surveys within the programme include patients at acute NHS trusts and mental health trusts. Surveys can be found at [www.cqc.org.uk/surveys](http://www.cqc.org.uk/surveys)

The surveys are run by eligible NHS organisations, or more commonly by 'approved contractors' working on their behalf. Results are then collated by the Surveys Co-ordination Centre based at the Picker Institute Europe and sent to CQC. This statement will therefore cover various quality assurance processes; policies at a CQC organisational level, methodology work undertaken by the Survey Co-ordination Centre based at Picker Institute Europe and business as usual practices carried out by the CQC patient surveys team. The following diagram provides an overview of the relationship between the different organisations involved in creating patient experience data.



**Fig 1. Overview of organisations involved in production of patient experience statistics**

## Commitment to quality

At CQC, there is a clear organisational structure for managing quality. There is an institutional-wide policy and a five stage process; planning, reviewing, analytical clearance, organisational sign-off and learning and feedback. The Intelligence Directorate Quality Assurance (QA) framework is available for users upon [request](#).

The surveys team has a nominated QA champion who oversees all procedures. Each survey is allocated a senior analytical owner (SAO) and a senior responsible owner (SRO), who break down the survey into its component parts and establish where and when each stage of the QA framework applies. At the development stage of a survey, various tests and reviews are carried out to ensure its accuracy and fitness for purpose. The first level review of any national survey is conducted by an external expert with the required technical and statistical knowledge outside the CQC's Survey team. The Survey Co-ordination Centre fulfils this function. Experts and users are also consulted during the development of each survey for views and feedback. For example, for redevelopment of the 2014 community mental health survey, a stakeholder consultation event was held at CQC headquarters in London where a number of interested stakeholders were invited to discuss priorities around:

- Current uses of the survey and its results
- Topics for the questionnaire
- Changes in policy and regulation that affect service provision and priorities
- Future uses of the survey

More information on the redevelopment project can be found [here](#) on the NHS surveys website. The final level of review is conducted by the Research and Survey Officers and Analyst Team Leaders in the Survey team.

Guidelines are clearly defined in the surveys team on how to implement quality management within the statistical production process and analysing results. QA templates are used describing the different QA processes prior to publication of survey results, including but not limited to: data cleaning, weighting for national tables, significance testing, benchmarking, comparability analysis, proofreading, and measuring response rates.

## Sound methodology

CQC has a clear methodological infrastructure for quality assurance. Quality guidelines are made available to all users at least in a summary version. At the directorate level, robust QA processes are specified to ensure the accuracy of the data we use in our products that we obtain from third parties. This framework will also be shared with the third party teams who supply data to CQC, and their confirmation sought that the data they have provided meets the quality standards in this framework. If they are unable to confirm this, then we will ask them to be clear where it does not meet this framework, and ask them for the caveats that apply around the data. For the NPSP, CQC consults experts and stakeholders before developing guidance in advance of the collection of the sample for each survey. This provides approved contractors and in-house trusts with guidance on how to undertake the sample and how to check it for accuracy.

Examples from the Community Mental Health Survey 2014:

### [Sampling guidance](#)

[Templates](#) for building the samples pre and post DBS checks are provided and published to ensure consistent construction of samples

[Compliance declaration form](#) is published so that trust can confirm that the sample is drawn in line with the guidance and has been checked.

CQC is committed to learning and feedback. Specific training courses support the quality policy and are available to relevant staff on a regular basis via the CQC learning and performance appraisal system. Being able to undertake QA is a key competency within the Intelligence competency framework. All staff within the surveys team have the required level of capability necessary to carry out their aspects of the QA framework which are assessed at recruitment.

There is a consistent methodological format for users. Respondents using self-administrated questionnaires are provided with all necessary documents (i.e. letters, questionnaires, leaflets.) These documents are reviewed in advance of every survey. All patient facing survey materials available on the NHS surveys website are also reviewed by an NHS Medical Research and Ethics Committee in advance of publication. All trusts must use the patient facing materials made publically available for the administration of the NPSP. As part of the design process we re-evaluate the patient facing materials to identify whether any changes are required. These materials might change in response to feedback received from the NHS Medical Research and Ethics Committee or Confidentiality Advisory Group regarding information to be given to patients, or to keep abreast of good practice in survey material design (the responsibility for which lies with the Survey Co-ordination Centre at The Picker Institute Europe). Procedures are in place to answer respondents' requests and complaints; each participating trust (whether in house or using an approved contractor) must provide a helpline number for respondents to call with queries/ complaints. Support is given to respondents in the form of a multi-language sheet, with a translation service and MenCap number provided. Participating organisations may also organise their own support mechanisms. The Co-ordination

Centre also have survey email addresses and a helpline number to deal with any queries.

### Revision procedures:

At present, NPSP data is not subject to any scheduled revision as they 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 NHS Surveys, as appropriate, and previously published results for the same survey are not revised. The [revisions policy document](#) also features on the CQC website on the main surveys webpage.

### Appropriate statistical procedures

#### Survey design:

Prior to data collection, survey questionnaires are tested by appropriate methods (e.g. cognitive interviews and focus groups or piloting via a sample of NHS trusts). For existing surveys, CQC and the Co-ordination Centre undertake secondary analysis on the previous year's survey data (ceiling/floor effects, item non response, correlations) to identify items that may require amendment. Where changes are made all surveys are cognitively tested to determine construct validity. For surveys undergoing substantial re-development, qualitative work is undertaken in advance of questionnaire design to determine what aspects of policy, patient/service user experience need to be reflected in the questionnaire. All questions are cognitively tested with the target population. For brand new surveys, depending on the patient group and survey data collection mode, we may undertake a small scale dress rehearsal pilot where the survey is rolled out as proper and we analyse the data collected from the survey. The development reports are always published on the NHS Surveys website, please see [here](#) for the 2014 report for Community Mental Health. We always seek to make methodological improvements to our surveys. For example, we are running a pilot to test methods to increase response rates alongside the 2015 Inpatient survey.

All surveys within the NPSP follow the principles of best practice around survey design, namely using probability (or pseudo probability) sampling methods to allow for comparability between organisations, patient sub groups and to enable statistical generalisations to be made about the patient population. For questionnaires, we follow the tailored design method (Dillman, 1978<sup>1</sup>), and all questions are cognitively tested (Tourangeau, 1984<sup>2</sup>). The sampling approach is reviewed for every survey.

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<sup>1</sup> Dillman, DA (1978) *Mail and Telephone Surveys: The Total Design Method*. John Wiley: New York.

<sup>2</sup> See Tourangeau, R. (1984) 'Cognitive science and survey methods: A cognitive perspective' In T. Jabine,

Sample designs are not periodically renewed for recurrent surveys unless there are concerns about sample coverage, response rates or there is a known change in the way services are provided since a previous survey affecting sample composition; as any substantial changes to sampling will result in a break in the time series data for a survey. Sampling is reviewed in advance of each survey and if changes are required, these are piloted with either a random sample or all trusts.

## Sampling:

Standard errors for point estimates of trust-level scores are computed using a 'complex samples' method. These are not reported directly, but are incorporated into the calculation of control limits using the approach described in Spiegelhalter's paper<sup>3</sup> and published in the technical document for the survey. The Co-ordination Centre also publishes a report for each survey detailing the sampling errors undertaken and these are available in the relevant survey folder on the NHS survey website. These reports detail major errors (which require re-sampling) and minor errors (which require correction). It should be noted that survey results are not adjusted for non-response. No seasonal adjustments are carried out – the need for this is avoided by conducting sampling for each iteration of the survey during the same period each year. This does mean that results reflect care at that particular time rather than claiming to be generalisable across a wider timescale. Trust results are case-weighted to adjust the achieved sample to a standard demographic profile across the survey. The weighting scheme is published in a [technical document](#) for the survey.

For almost all surveys, the mode tends to be a paper self-completion questionnaire mailed to people's home addresses. This is a fit for purpose model that enables a large volume of data to be collected across a wide geographical area in a standardised way, and following the devolved method of the NPSP. Where a patient population would be better accessed and surveyed using a different method, the Survey Co-ordination Centre have done this, such as in the case of 'hear and treat' patients who call 999 (see the 2013 Hear and Treat Service Users Survey) which used a computer assisted telephone interviewing (CATI) system. They have also investigated introducing an online mode into the NPSP during a number of pilots (such as on A&E 2012, Inpatients 2013 and the 2014 Children's Survey), however, the results have meant that we have not advised moving towards the universal introduction of an online mode or mixed mode approach for the NPSP.

Each of the surveys within the NPSP (unless administered using a CATI data collection mode) follow the principles of the tailored design method. This means that up to two reminders are sent to non-respondents during the course of the survey fieldwork. As the NPSP follows a devolved administration process, a standard data

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M. Straf, J. Tanur, & R. Tourangeau (Eds.), *Cognitive aspects of survey methodology: Building a bridge between disciplines* (pp. 73–100). Washington, DC: National Academy Press.

<sup>3</sup> Spiegelhalter D (2005) 'Funnel plots for comparing institutional performance' in *Statistics in Medicine*. 24(8):1185-1202.

entry template is provided for all participating organisations to use to enter the response data. A data cleaning manual is also provided alongside this template to guide organisations about the cleaning processes that will be undertaken on the national data. [Data cleaning](#), undertaken by the co-ordination centre, is conducted using SPSS syntax meaning that a comprehensive audit trail of the steps taken in the data management and cleaning processes is documented.

## **Non-excessive response burden**

Response burden is measured periodically by the Co-ordination Centre, with particular attention on questionnaire length and language used, i.e.: to reduce the burden (both in cognitive terms and time) on respondents. CQC follows best practice principles and keep the length of the questionnaire to a maximum of 12 pages. We focus on the questions that are prioritised as most important to stakeholders. This will take about 15-20 minutes maximum for an average respondent to complete and allows us to gather data on the key aspects of patient experience needed for performance management and regulatory requirements. With respect to language and cognitive burden, we try to minimise the time lag between the attendance at hospital and when the respondent receives a question: this helps to aid recall and therefore reduces the cognitive burden (subscribing to Tourangeau's model of cognitive response).

The content of the survey is also cognitively tested: not only to test construct validity (measuring the same concept universally across the patient population) but also to determine that the language used is easily understood by the group we are surveying. This, again, will reduce the cognitive burden as it will be easier for respondents to understand, match their experience to one of the response options and select the most appropriate. We only collect information that is considered necessary. At sampling stage we collect the minimum of information that is used for analysis purposes, and these decisions are approved under our S251 approval. Furthermore, when supplying data back to trusts, the benchmark methodology and reports are designed to provide comparable results in a readily understandable format and are accompanied by documentation setting out the methodology. Trusts are provided with additional 'raw' results enabling greater understanding of how patients responded. Data is shared at respondent level with NHS England and the Department of Health. An anonymised dataset is deposited with the UK Data Archive for access by the wider community.

Sampling requirements are kept as simple as necessary to achieve statistical aims but also to enable trusts to undertake these in a systematic and manageable fashion. Where more complex sampling arrangements have been made these are piloted to ensure they can be delivered effectively. In defining the sampling criteria for surveys, attention is given to any patient groups likely to experience distress as a result of receiving a questionnaire. If this is a risk, this group would be excluded and their exclusion is registered with the applicable ethics committee approving the survey. For example, the National Maternity Survey excludes women whose baby died

during or since delivery, those who had a concealed pregnancy and those women whose baby was taken into care. These decisions are taken after consultation with national stakeholders.

Our engagement strategy sets out how we intend to extend the level of consultation with external stakeholders. To ensure the demands made of NHS trusts and patients (respondents) are proportionate and necessary, stakeholders will be consulted about any proposed changes to the established survey cycle.

## **Cost-effectiveness**

The estimated costs for trusts to undertake the Survey Programme are derived from the contract costs that trusts hold with their approved contractors. These contracts include the procurement of a range of services that allow for the sampling of patients, mailing out of questionnaires and reminders, managing responses and preparing the data for the Co-ordination Centre. In addition, trusts may also procure additional local services including early reporting and the management of local surveys. CQC also seeks to keep any additional costs of new developments and requirements to a minimum and where changes are proposed to the survey establishment, these will be reviewed with stakeholders. Currently decisions about any change to methodology are reviewed and direct costs to trusts via their contracts with approved contractors are assessed.

Resources are used as effectively as possible, and trusts are advised on the costs of using a contractor or the resources required to conduct the survey in-house, with a breakdown of all expenditures. The approved contractor's model allows for administration of the survey in a cost effective manner by encouraging economies of scale. Currently, when using approved survey contractors, trusts can take advantage of contractors' more efficient methods e.g. most contractors use Royal Mail's 'Walksort' service, which reduces the cost of mailing by over a third; trusts using standard mail rates would pay more for each questionnaire mailed out than a contractor would using Walksort. We believe competition between contractors keeps costs down without compromising the quality of work, due to the requirement to maintain standards relevant to the approved contractor status. Approved contractors also offer packages to trusts, for example whereby they conduct all acute national surveys, which drives costs down even further.

An assessment of pre-existing administrative data sources negating the requirement for a survey is carried out prior to launching any new survey. As part of designing the sampling approach for any new survey within the NPSP we conduct desk research and liaise with trusts about the data recording systems they use and the information collected, and stored, on them. The information we gather from this scoping process enables us to determine what sampling fields we are able to collect, how accurate the data will be and how complicated a sampling method we should design. Piloting of sampling methodology with trusts means a survey would only run if the data to be gained were considered robust.

## Relevance

There are various processes in place to consult users, monitor the relevance and utility of existing statistics in meeting their needs, and consider their emerging needs and priorities. Our User Engagement Strategy sets out how we will ensure a wide group of stakeholders are able to contribute to the ongoing relevance and utility of the patient survey programme. Currently stakeholders contribute to the development of specific surveys, either when a new survey is developed, or when a longer standing survey is being redeveloped. Stakeholders external to CQC will include patients, NHS trusts, national representative bodies and organisations such as NHS England or the Department of Health. They contribute in identifying questions areas, in proposing specific wording of questions, and the development of sampling methodology. When new questions are proposed between survey cycles, the utility of the ensuing data is assessed to ensure questionnaire space is allocated to questions that will have impact.

CQC lists key users for each survey with their uses and requirements identified. The User Engagement Strategy published in November 2015 sets out how we will schedule regular consultation across the programme, rather than on a survey by survey basis going forward. The first large scale consultation is scheduled for Spring 2016.

## Accuracy and reliability

CQC has systems in place for assessing and validating source data and statistical outputs. Internal procedures and guidelines for data quality assessment exist and address accuracy and reliability issues:

- Identification of the main sources of error for key variables
- Quantification of sampling errors for key variables.

For each survey within the NPSP, at the sampling stage all samples are checked before permission is given to mail out questionnaires. This helps to identify where a trust may have drawn their sample incorrectly with implications for coverage.

Samples are checked firstly by the trust's approved contractor, and then by the Survey Co-ordination Centre. The latter checks are conducted on an anonymised sample file meaning that patient names and addresses can be checked at the first stage only. [Sampling error reports](#) are available on the NHS Surveys website.

Quantification of potential measurement errors take place at the cognitive testing stage. There is no treatment of non-response at estimation stage;

representativeness is assessed by comparing demographics of responders.

However, we are working on how to compare total and achieved samples on the basis of the stratification cells.

The Quality Assurance Framework used by the Intelligence Directorate within CQC has been outlined previously in the 'Commitment to Quality' section. This framework underpins the specific quality assurance mechanisms used by the team responsible

for patient experience statistics. They include the use of quality assurance checklists when receiving and reviewing data, with a requirement for senior level analytical clearance before any survey data can be shared beyond the team.

## Timeliness and punctuality

The survey timetable is available to users on the [CQC surveys website](#) with provisional month of release noted twelve months in advance and exact day confirmed at least one month in advance. In compliance with Protocol 2 of the Code of Practice for Official Statistics survey results are:

- Released as soon after fieldwork as possible, subject to full quality assurance and analytical clearance within CQC. CQC would always refuse to withhold or delay a publication for non- statistical reasons.
- Made available to the public at 9.30am on a weekday.
- If any planned changes need to be made to the pre-announced release dates, the statistical reasoning will be explained within the 'outline programme' on the CQC website and via .GOV.UK. The CQC Patient Surveys team would alert NHS trusts and approved contractors to any change in date and the statistical reasoning for it via the surveys co-ordination centre, and alert NHS England through the designated contacts.
- Shared with a restricted number of individuals within CQC and NHS England in compliance with the rules and principles on pre-release access set out in legislation. This includes limiting access to England level results before public release to those people essential for production and publication, and for quality assurance and operational reasons. Records of those who have access prior to release are published alongside survey results.

## Coherence and comparability

Surveys within the NPSP are presented in a consistent manner using the same benchmarking methodology across surveys and adopting a standard reporting format for statistical outputs. Meaningful comparisons based on a robust methodology are included in publications, both nationally between years and between trusts using a [scoring system](#). Benchmark reports are presented that allow users to see how a trust is performing in relation to all other trusts that took part in the survey. From this, areas for improvement can be identified. The data shows performance relative to other trusts: there are no absolute thresholds for 'good' or 'bad' performance. England level results are compared to other UK data collections where possible and relevant. For example the survey of 'women's experiences of maternity care' has a comparator in Scotland, as does the Adult Inpatient Survey.

CQC is committed to presenting in a clear and understandable form, released in a suitable and convenient manner, available and accessible on an impartial basis with supporting guidance. The surveys are designed in a way that means that

comparisons over time are considered a priority and unwarranted changes to methodology and questions are discouraged. Consistency allows NHS trusts and others to assess how performance is changing over time. Respondent profiles are compared over time and changes to profiles are highlighted in statistical reports.

Survey methodology is kept consistent as far as possible given most surveys are based within the acute sector. Sampling criteria and methodology will differ as necessary to fit the target population, but questions where possible would be the same across surveys as would survey administration mode and implementation. Where change to methodology is necessary i.e. new processes implemented to satisfy requirements of national approval bodies, these are communicated to all participating trusts and contractors via e-bulletins and web conferences.

## **Accessibility and clarity**

Recently our national level reports have been redesigned to improve the narrative and contextual information provided. The visualisations (charts and tables) included within our publications have also been reviewed with standard guidance produced to ensure consistency across surveys, and adherence to [good practice](#) published by the Government Statistical Service.

All England level publications are reviewed by the CQC publications team to ensure they are written in plain English, suitable for a wider audience and compliant with requirements under the UK Statistics Authority Code of Practice. Trust level outputs, in particular the benchmark results found for trusts on the CQC website, have been tested with members of the public to ensure they are meaningful and easy to interpret. Data tables are made available on the website allowing open access to data tables for national and trust level results, with a full explanation for users. Respondent level data continues to be made available via the UK Data Archive to enable people to undertake their own analyses. A patient surveys mailbox ([patient.survey@cqc.org.uk](mailto:patient.survey@cqc.org.uk)) is monitored by the surveys team to deal with external data queries. All current national publications and trust results can be found on the CQC website. The [NHS surveys website](#) publishes all historical survey results, and all guidance and implementation materials for each survey.