

## **Quality Statement**

### **Overall Patient Experience Scores**

### **Published by NHS England**

## **Introduction**

This quality statement accompanies the National Statistics publication of the Overall Patient Experience Scores. This statement and the relevant statistics are available on our main publication page for patient experience:

[www.england.nhs.uk/statistics/statistical-work-areas/pat-exp/](http://www.england.nhs.uk/statistics/statistical-work-areas/pat-exp/)

NHS England calculates these scores from data arising from the NHS Patient Survey Programme, which is overseen by the Care Quality Commission (CQC). We do not directly control the surveys, so in effect we are using the data as an administrative source, to derive our National Statistics.

In assessing quality, we have given careful thought to our own quality control processes, but also to the quality assurance measures we need to have in place to make sure that the whole system meets requirements.

The surveys are conducted as a rolling programme, with different NHS service areas surveyed in different years. Our results are based on data from four settings:

- Adult inpatient
- Emergency department
- Community mental health, and
- Outpatient

In practice, the surveys are run by individual NHS organisations, or by contractors working on their behalf, and results are then collated nationally by Picker Europe, on behalf of CQC.

The methodology NHS England uses to compile these statistics is described in full in our 'methods, reasoning and scope' guidance. This forms part of the 'supporting information' for the Overall Patient Experience Scores series, further information is available on the NHS England statistical web pages.

This document assesses the statistics against the following dimensions of quality:

- Relevance
- Accuracy
- Timeliness and punctuality
- Accessibility and clarity
- Comparability, and
- Coherence

## Dimensions of quality

### Relevance

It is important that the statistics produced are relevant to user needs and that they meet the needs of users, both in coverage and in content. In brief, the aim is to condense the information in the wider-ranging NHS Patient Survey Programme into an overall set of scores, or measures, that show how the NHS is performing on patient experience.

Users have told us that it is important that this information provides a broad overview of user experience across aspects of most importance to patients. It is also important that results are compiled in a way that allows valid comparisons over time.

Careful consideration has been given to who data users are, and this information is covered in the NHS England 'customer service and user engagement statement'. For further details please see the NHS England statistical web pages.

In brief, these statistics were originally designed to meet the needs of internal customers within the Department of Health, who were originally responsible for the publication of the overall series, to meet broader accountability requirements across Government. The results have subsequently been very widely used by external data users in the NHS.

In order to continue to meet the needs of external data users, NHS England, who took over responsibility for the production of the series with effect from April 2013, will continue to seek feedback and act on comments received from users. The NHS England 'customer service and user engagement statement', available on the NHS England statistical web pages, sets out how we are adapting our user engagement approach to provide more routes in for other external users, including academic researchers, media and members of the public.

These statistics are an overall measure of experience, with a focus on issues important to patients and compiled in a way that allows comparison over time. Some internal users have observed that the statistics meet this need directly, almost by definition, although there is more than one way to define overall experience. The feedback received in the past has had a broader range of users highlighting areas where some user needs are not fully met.

The key points to note are:

- Confusion with other data sources. Our 'methods, reasoning and scope' guidance explains the distinction between measures of public opinion, user satisfaction and user experience. These statistics relate to the third of these
- Frequency and timeliness: users have expressed the view that they would like more frequent updates. Given the data is derived from a third party source it is not in our remit to increase the frequency
- Measure not responsive to change: this is important for a performance measure. The current view is that the measure is responsive to change, but that observable change has only been seen in a few areas
- Lack of clarity: our 'methods, reasoning and scope' guidance, together with the detailed commentary attached to the figures are designed to address this feedback
- Methods, no confidence intervals: these have now been added to the latest publications

Overall, the statistics meet, and are relevant to, the expressed needs of users. NHS England will take steps to improve engagement with external users, in order to better understand their needs.

### Accuracy and reliability

These statistics relate to the population of people who recently used the NHS, and the factor of interest is an indication of the average or typical quality of experience for that population. Our statistics estimate this value from existing survey data (used as an administrative source), using a defined methodology.

In May 2011 the commentary that accompanied each publication was extended to include confidence intervals for the latest statistics. These confidence intervals show how accurately the statistics derived from sample surveys estimate the equivalent population parameter.

There are a number of potential sources of error in this process, but each of these is successfully controlled. Although NHS England uses the data as a third party, we have sought assurance on each stage of the process. The key points are:

- Picker Institute carry out cognitive testing of the underlying survey questionnaires with a pilot sample of patients, to ensure that respondents understand the questions in the way intended
- Picker issue NHS trusts and their contractors with detailed guidance to improve data collection and cleaning (see for example <http://www.nhssurveys.org/surveys/952>). This minimises the risk of any sampling or processing errors
- Sampling follows a simple random sample design, with parameters

- carefully defined by Picker to prevent bias or sampling error
- The resulting data are processed by Picker, CQC and NHS England according to a set 'recipe book' outlining the methodology for computing scores. This minimises processing error
- The detailed methodology used to produce these figures is published in our 'methods, reasoning and scope guidance
- Senior sign off assurance from CQC to NHS England is included in the process.

The Picker Institute monitor the quality of surveys run by trusts and their contractors, and reject data where standards are not met, for example, the 2010 Inpatient Survey results excluded one trust which did not run the survey on the agreed dates.

As in any set of statistics based on surveys, we need to consider any possible sources of bias in the survey responses or the survey design. Samples for these surveys are selected by simple random sample from NHS records, and are large enough to minimise any sampling error (for example, errors arising, by chance, by selecting a set of patients who happened to have a more positive experience). The number of received responses is also large, usually over 60,000 for the Inpatient Survey, and enough to ensure that sampling error is very small.

There is potential in these statistics for non-response bias, where the group of patients who respond to the surveys are in some way different from, or not representative of, all patients. This type of bias might arise, for example, if patients with more negative views of the service were more likely to respond.

Non-response bias has not been tested directly, however NHS England note that the effect is mitigated by the survey methodology. Results are collected via postal surveys with assured confidentiality for respondents (and NHS England receives only anonymised data without any identifying information). This helps to reduce the effects of 'gratitude bias' that can arise when patients give face to face feedback to clinicians. The overall style and design of the questionnaires is well rounded, and allows for respondents to record a range of different perceptions or perspectives. Individual questions are also subject to careful cognitive testing before being introduced to the survey.

Nevertheless, there is some evidence that patients from some demographic groups are less likely to respond, particularly those in black and minority ethnic groups, those aged under 35 and, to some extent, male respondents.

The sample for these surveys is selected by simple random sampling from NHS databases. Those databases contain demographic information about the patients, including age, gender and ethnic category. That information is included in the data we receive from the organisation that administers the survey. It is also possible to link this information to survey responses. For each demographic group it is possible to see how many people were sent a questionnaire and how many sent a response. This allows the calculation of a

response rate for each group.

Table 1 shows these response rates, expressed as a percentage for the 2010 inpatient survey. For example, of the questionnaires sent to white males aged 16-35, around 20.7% of them were completed and returned.

**Table 1: Survey questionnaires filled in and returned, as a percentage of questionnaires sent out. (Results from 2010 Inpatients survey)**

Sex	Age band	Ethnic Category					Total
		White	Mixed	Asian or Asian British	Black or Black British	Chinese or other	
Male	16-35	20.7	22.6	19.2	16.7	20.9	20.5
	36-50	35.0	28.0	25.2	29.0	30.7	34.0
	51-65	56.0	46.0	36.6	41.6	43.3	54.7
	66+	58.4	51.4	39.4	44.3	42.6	57.4
	All Ages	49.5	34.5	30.8	32.9	34.5	48.0
Female	16-35	30.9	25.8	25.6	19.6	24.4	29.7
	36-50	46.3	37.2	36.5	36.0	36.5	45.0
	51-65	62.8	49.3	35.2	43.8	43.7	60.8
	66+	52.6	49.3	33.0	37.1	39.1	51.8
	All Ages	50.3	36.9	32.3	32.8	35.0	48.8

Organisations directly involved in administering this survey have investigated ways to increase response rates amongst groups with relatively low rates (although response rates remain sufficiently high to keep sampling error small within each group). The most substantive adjustment was to extend the fieldwork period by a further 4 weeks from 2007 onwards. There was evidence that under-represented groups were less likely to respond in the first wave of survey responses, so extending the fieldwork increased representation for those groups.

In circumstances where there are different response rates for different groups, it is sensible to consider appropriate weighting of responses, to ensure that views from these groups are accurately represented in the results.

When this series was established, analysis was carried out to establish whether different weighting schemes affected the overall results. It was found that weighting by ethnic category did not alter the overall results substantially. There is also a 'cost' to weighting. Each additional weighting variable adds to the complexity of the method, and increases the risk of having very large weights assigned to individuals in very small groups, which can result in fluctuations in results from year to year (and for users who have expressed a view, the consistency of this series over time is particularly important). This is particularly challenging for the ethnic category question because white respondents predominate in the population and some of the other groups are

therefore very small.

Our 'methods, reasoning and scope' guidance explains the assessment of the need to weight responses to give standardised results for each NHS organisation. Responses are weighted by sex and age band but not ethnic category.

Typically, these statistics are reliable and accurate to within around +/- 0.2 points.

### **Timeliness and punctuality**

NHS England uses these data as a third party, and is therefore (to a large extent) bound by the timetable for the underlying surveys.

As an example, a typical timetable for the adult inpatient survey within the NHS Patient Survey Programme might be as follows:

- Patient episode: June to August year 1
- Survey fieldwork: September year 1 to January year 2
- Data cleaning, collation and checking: January to February year 2.
- Analysis of data by CQC and Picker: February to March year 2
- Supply of data to NHS England: March year 2
- Publication of results by CQC and NHS England: April year 2

This schedule is timely given the normal constraints of collecting survey data from service users and the resulting requirements for data checking and validation. With regard to the NHS England stage of the process, publication is sought as quickly as possible following receipt of the relevant data.

Releases are always punctual, and on the pre-announced dates. Pre-announcement of the precise date may occur up to four weeks before publication since NHS England must adhere to CQC's publication timetable for the underlying data set. We always pre-announce the month of publication in our 12-month planning schedule.

### **Accessibility and clarity**

The release is available free of charge on our main publication page. NHS England notifies all known individual users of the latest data availability on the day of release.

Documentation and presentation of these statistics has been improved to clarify purpose, methodology and interpretation.

The release meets government's Public Data Principles by presenting all data in Comma Separated Value (CSV) format in addition to Portable Document Format (PDF) and Microsoft Excel files.

## Comparability

These statistics relate to England, and there are no directly comparable figures to allow comparisons with other UK nations or internationally. The Government Statistical Service (GSS) Health and Social Care Theme brings together statistical activity from across the UK devolved administrations reflecting both common ground and differences between the administrations.

The Organisation for Economic Co-operation and Development (OECD) published four indicators of patient experience in the 2013 edition of 'Health at a Glance'. Data are available for fourteen OECD countries including the UK. The measures are not exactly comparable to the overall patient experience scores for England but can provide useful context.

It is central to the purpose of these statistics that results are comparable over time (subject to careful consideration of any confidence intervals). In all underlying survey questionnaires, the relevant questions are held unchanged from year to year to enable comparability. Where changes to questions or responses occur, the changes are fully assessed and any discontinuities in the data are fully disclosed in the release.

The focus of the publication is on national level (England) results, but scores are provided at NHS trust level. Statistics on directly equivalent measures in different trusts are comparable (subject to consideration of the larger confidence intervals at trust level, typically +/- 2 points).

Data on ethnicity use the definition consistent with the 2011 Census, as recommended across the GSS.

The release describes how these statistics are not designed to allow direct comparisons between different NHS service areas, such as Inpatients and Primary Care, or to allow direct comparison of different aspects of care (for example is 'access & waiting' better than 'better information, more choice'). Comparisons of this type are not advised for these data.

## Coherence

These statistics are drawn from the same source, and use a coherent and consistent methodology. However, it is helpful to put these measures in broader context. Our 'methods, reasoning and scope' guidance explains the relationship between measures of:

- Public opinion of services
- User satisfaction with services
- User experience of services.

These statistics relate to the third of these, and do not relate in any way to the two other categories. The 'methods, reasoning and scope' guidance highlights

alternative sources of these other data.

There is a separate survey programme called the GP Patient Survey, commissioned by NHS England. This survey is not currently included in this set of results.

### **Confidentiality, Transparency and Security**

Survey contractors anonymise data before collation by the Picker Institute, no identifying information such as names, contact details, postcodes or dates of birth are disclosed to the Picker Institute, CQC or NHS England. NHS England holds databases securely, under the terms of our standard information governance arrangements, with access strictly limited.