

Service Access and Patient Experience Report October 2011

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1. Executive Summary

Demonstrating that patients, carers and communities from protected groups can readily access services and are not denied access on unreasonable grounds is key to delivering on our equality duty. This report looks at access to our service by protected characteristics as outlined in the Equality Act 2010. Where there are gaps in this data this is highlighted throughout the report and forms a key part of the recommendations.

The Trust's inpatient and outpatient data is used to show the overall picture of access across the characteristics and this is followed by snapshot of some services which will be built upon in future reports.

The overall picture of access, using the best available data, reflects broad similarity to local demographics however whilst our data around ethnicity, age, gender and religion has steadily improved there is a significant gap around the collection of data on disabilities and sexual orientation. A priority action, along with all equality issues, for securing improved outcomes is to institute a system of routine local monitoring of access to services, experience and outcome. In addition the following actions represent a summary from the analysis of the data included in this report:-

- Consider the reasons for peaks in age range data for the Emergency Department re-attendance figures.
- Identify gaps in data and identify inconsistencies to the lifestyle team. Further investigate access to smoking service for BME patients.
- Engage with Picker to encourage better representative sampling.
- Use disaggregated patient experience survey data to explore apparent inequalities.
- Restrict the recording of religion or belief to the census categories.
- Training for frontline staff in the reasons for collecting equality data and how best to ask questions to improve the response rate.

2. Introduction

Stockport NHS Foundation Trust is committed to providing services for our patients and their carers in a clean and safe environment, which improves health, treats disease and promotes independence. The Trust aims to live up to its vision to:-

“Provide high quality, accessible and responsive services by putting the patient at the heart of everything we do”

The Equality Act 2010 places a requirement on public bodies to assess their current provision, identify the needs of their ‘customer’ base and then work with those people to develop the right services, anticipating needs and differentiating the interventions in order to achieve equity of access, experience and outcome.

In addition the Department of Health has made tackling health inequalities a priority. It is under a legal obligation to promote equality across the characteristics protected in the Act and subject to Parliamentary approval, the new NHS Commissioning Board and clinical commissioning groups will be under a duty around reducing inequalities access to, and the outcomes of, healthcare.

The Trust recognise that some patients may face barriers to our services and could need extra help to ensure they receive the same access, treatment and outcomes. Monitoring access is crucial to establish any gaps in our service provision for patients from protected groups; these include age, gender, ethnicity, disability, religion or belief, sexual orientation and gender reassignment.

Demonstrating that patients, carers and communities from protected groups can readily access services and are not denied access on unreasonable grounds is key to delivering on our equality duty. We must also demonstrate that the experience of patients and carers from protected groups compares favourably with the experience of patients and carers as a whole

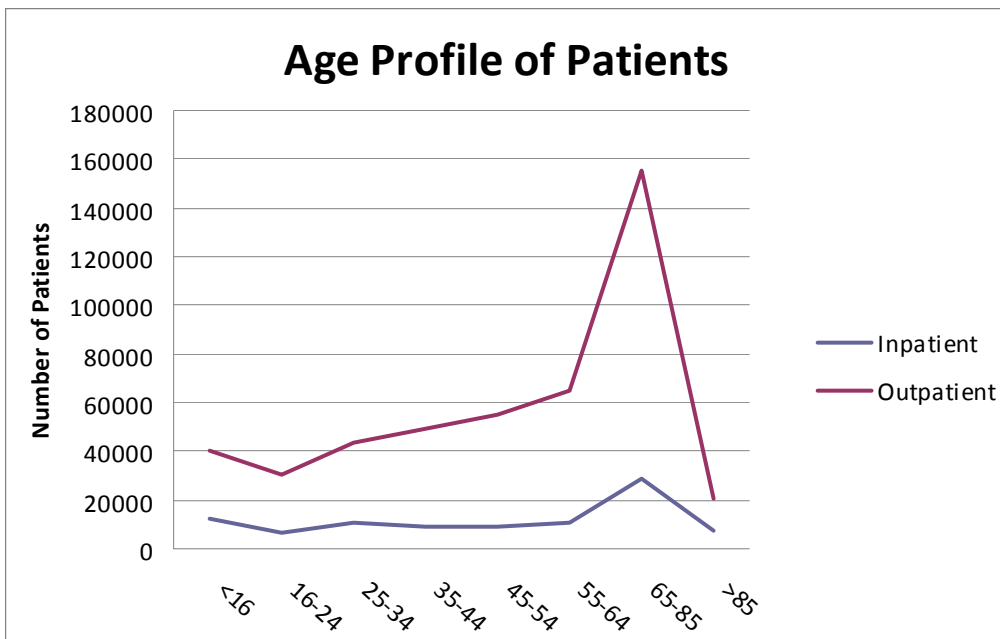
The purpose of this report is to build on previous monitoring reports to highlight, using the best available data, who is accessing our services and to gain a clearer picture of where there are gaps among community groups. We have also, for the first time disaggregated our patient experience reports by the protected characteristics to identify any patterns of inequality.

3. Inpatient/ Outpatient Data

From April 2010 to March 2011 Stockport NHS FT saw 554,709 patients, 459,677 out-patients and 95,032 in-patients. The following is a breakdown of these patients by age, gender, ethnicity and religion.

3.1 Age

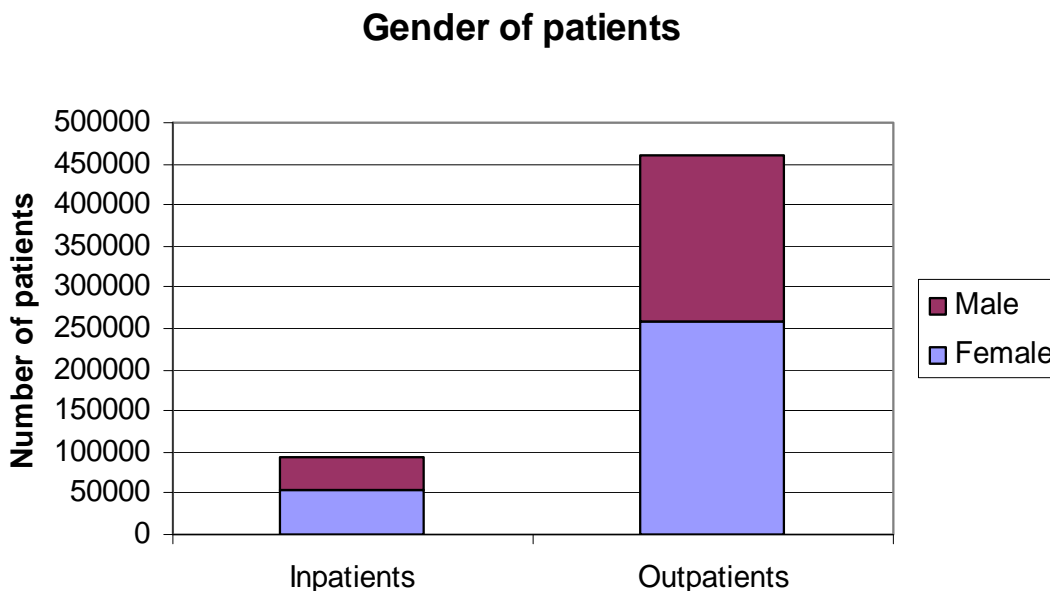
The age of patients attending the hospital is bias towards the older population, reflecting greater healthcare needs of this age cohort.



3.2 Gender

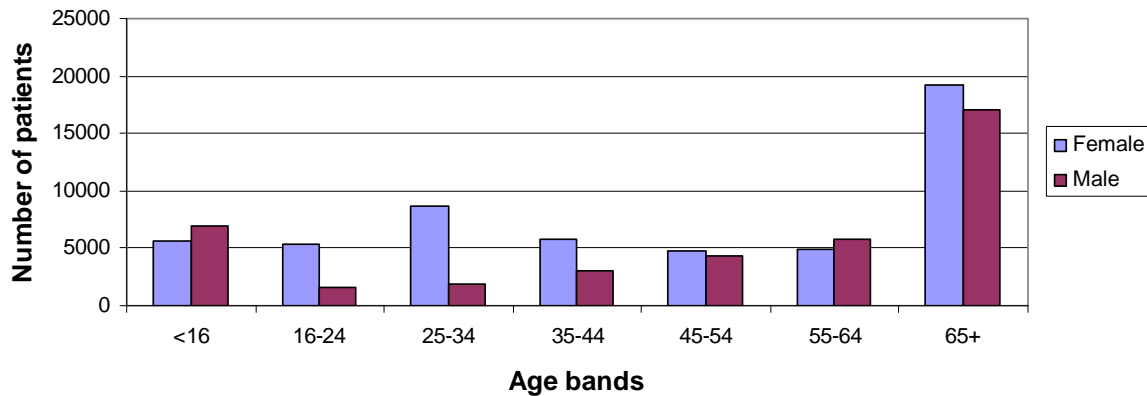
As with most healthcare services in the UK, women are more likely than men to use the Hospital at Stepping Hill – both as in-patients and as out-patients.

Despite making up just 51.29% of Stockport’s population, 57% of all patients at Stepping Hill hospital were female.

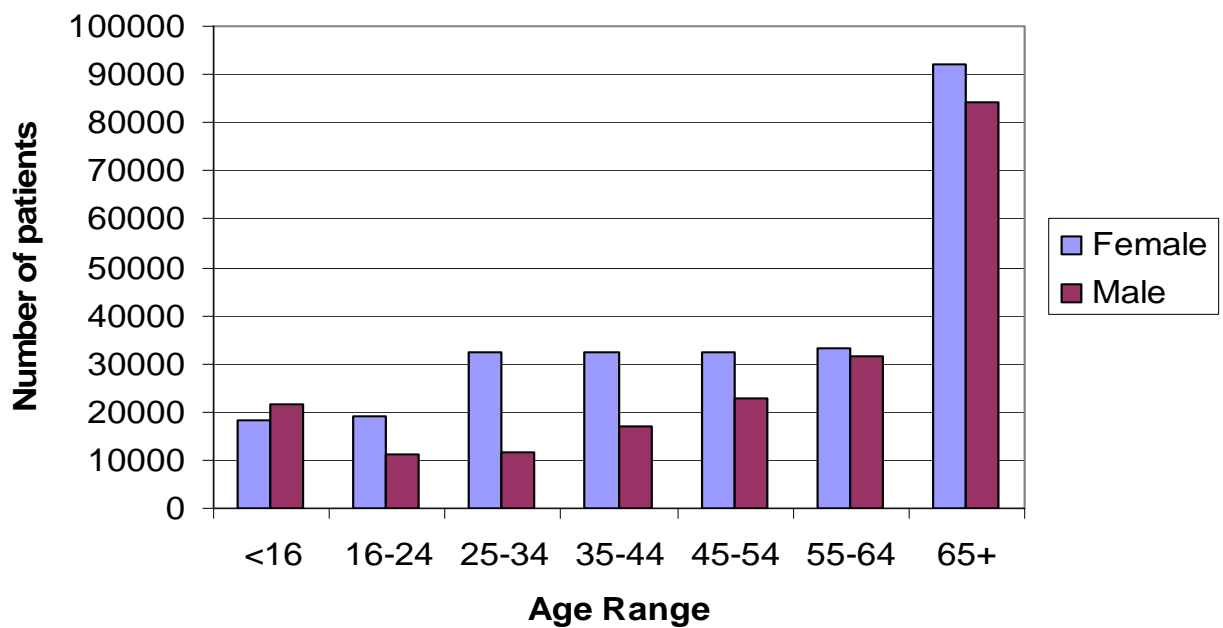


This reflects national trends, suggesting that women are more likely than men to seek medical attention. The graphs below highlight this trend with the peaks in male outpatient and inpatient attendance at the younger and older age bands.

**Gender/ Age
Inpatient Data April 2010 to March 2011**



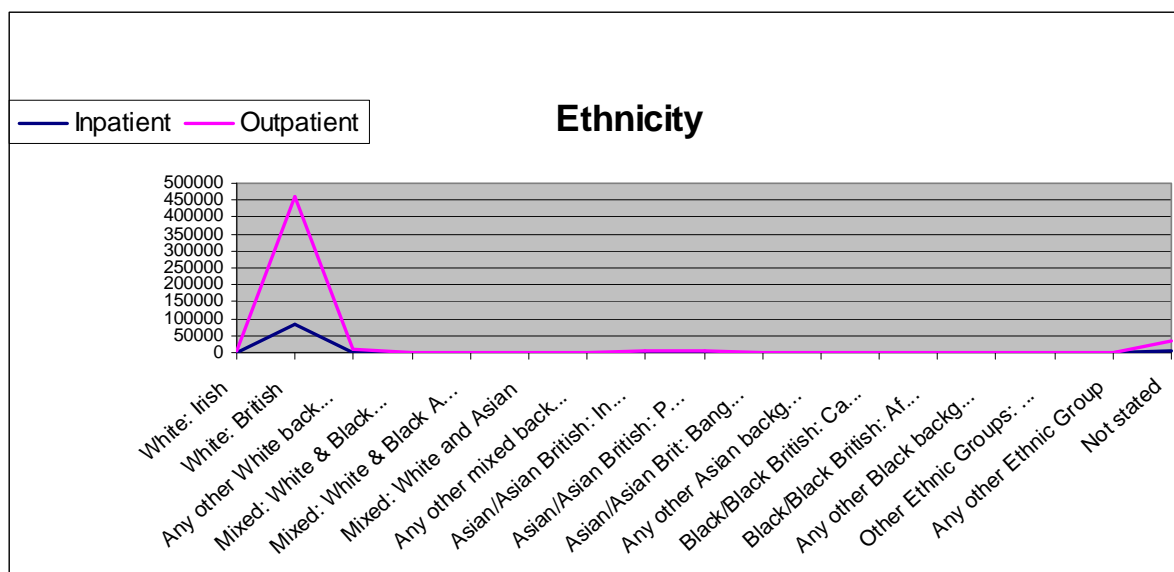
**Gender/Age
Outpatient Data April 2010 to March 2011**



3.3 Ethnicity

In terms of ethnicity, access to hospital services is reasonably reflective of the local population.

Ethnicity	In-patients 2009/10	Out- patients 2009/10	In-patients 2010/11	Out- patients 2010/11	Stockport residents 2001
White:					
British	86.3%	80.9%	87.0%	82.3%	92.9%
Irish	0.8%	0.9%	0.7%	0.9%	1.5%
Other White	1.8%	2.3%	1.8%	2.2%	1.3%
Mixed:					
White/Black Caribbean	0.2%	0.1%	0.2%	0.1%	0.3%
White/Black African	0.1%	0.1%	0.1%	0.1%	0.1%
White/ Asian	0.1%	0.1%	0.1%	0.1%	0.3%
Other Mixed	0.2%	0.1%	0.2%	0.2%	0.1%
Asian/ Asian British:					
Indian	0.5%	0.5%	0.5%	0.5%	0.7%
Pakistani	0.8%	0.8%	0.8%	0.9%	1.0%
Bangladeshi	0.2%	0.1%	0.1%	0.2%	0.1%
Other Asian	0.3%	0.3%	0.3%	0.3%	0.3%
Black/ Black British:					
Black/ Black Caribbean	0.1%	0.2%	0.1%	0.1%	0.2%
African	0.2%	0.2%	0.1%	0.2%	0.1%
Other Black	0.1%	0.1%	0.0%	0.1%	0.1%
Other:					
Chinese	0.3%	0.3%	0.2%	0.3%	0.4%
Other Ethnicity	0.4%	0.4%	0.4%	0.3%	0.1%
Total BME*	3.5%	3.3%	3.1%	3.4%	3.8%
Total BME + WME*	6.1%	6.5%	5.6%	6.5%	6.6%
Not given	7.8%	12.6	7.3%	6.0%	0%



Interpretation was used for 1,404 appointments at Stepping Hill hospital in the period 1st April 2010 to 31st March 2011. The top 10 languages were:-

Language	No of requests
Polish	310
Farsi	193
Cantonese	182
Urdo	157
Manndarin	146
Arabic	74
Bengali	60
Punjabi	29
Russian	27
Kurdish	26
TOTAL	1241

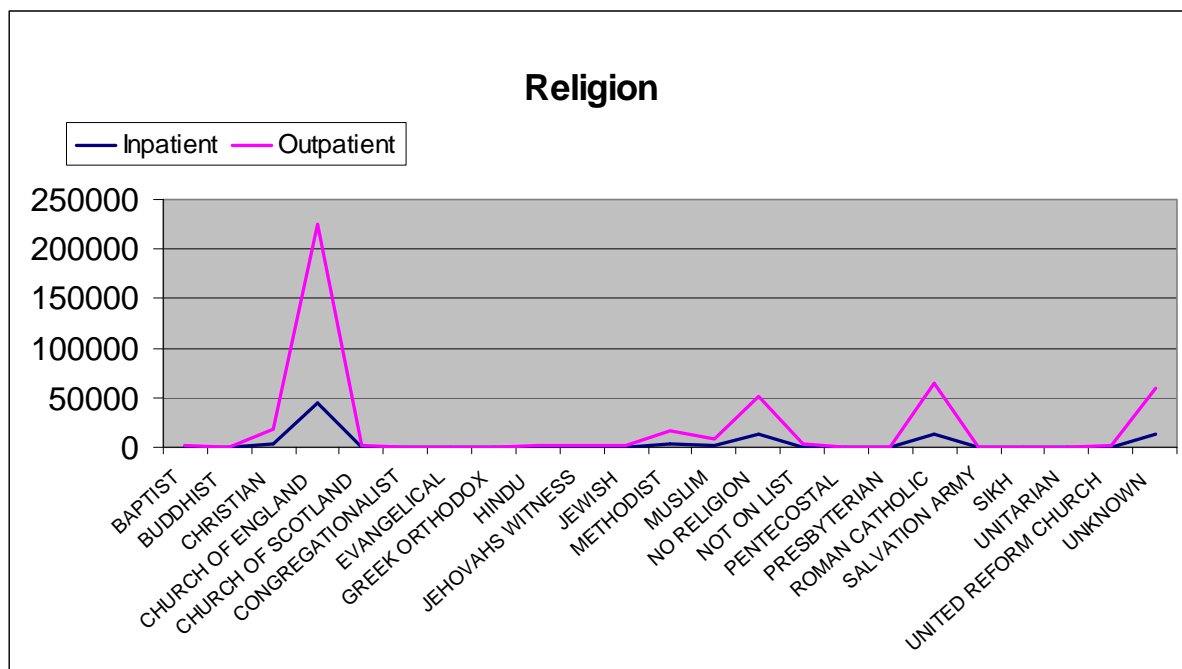
Interpretation was used most in the Women and Children's business group which reflects their strict adherence to policy and informed consent.

Business Group	No of Requests	No of Patients	Percentage
W&C	652		46.5%
Surgery	294		21%
Medicine	148		10.5%
D&CS	116		8%
Other	202		14%

3.4 Religion or Belief

To ensure that services are flexible to the spiritual needs and cultural beliefs of patients, the number of religions recorded at Stepping Hill Hospital is much higher than the generic categories recorded in census findings. As a result, at an initial glance it would appear that some religious groups are less likely or able to access the hospitals services.

For example, at the 2001 census, 75.42% of the Stockport population declared their religions are 'Christian', yet only 4.0% of patients at Stepping Hill Hospital recorded their religion as 'Christian'. However, when the number of patients from all denominations of Christianity are considered (including Church of England, Roman Catholic etc.) this figure rises to around 71%. Although this is still lower than census comparators, this is likely to reflect the increase in ethnic diversity in Stockport over the past decade since the census was conducted.



Reporting of religion or belief by patients is still quite low and the high number of religions recorded makes it more difficult to interpret the data. Although the Trust's reasons for recording many denominations is to facilitate patient choice a narrower monitoring choice that reflects the census categories may be more beneficial. However the indicative figures above would suggest that access to hospital services is reasonably reflective of the local population.

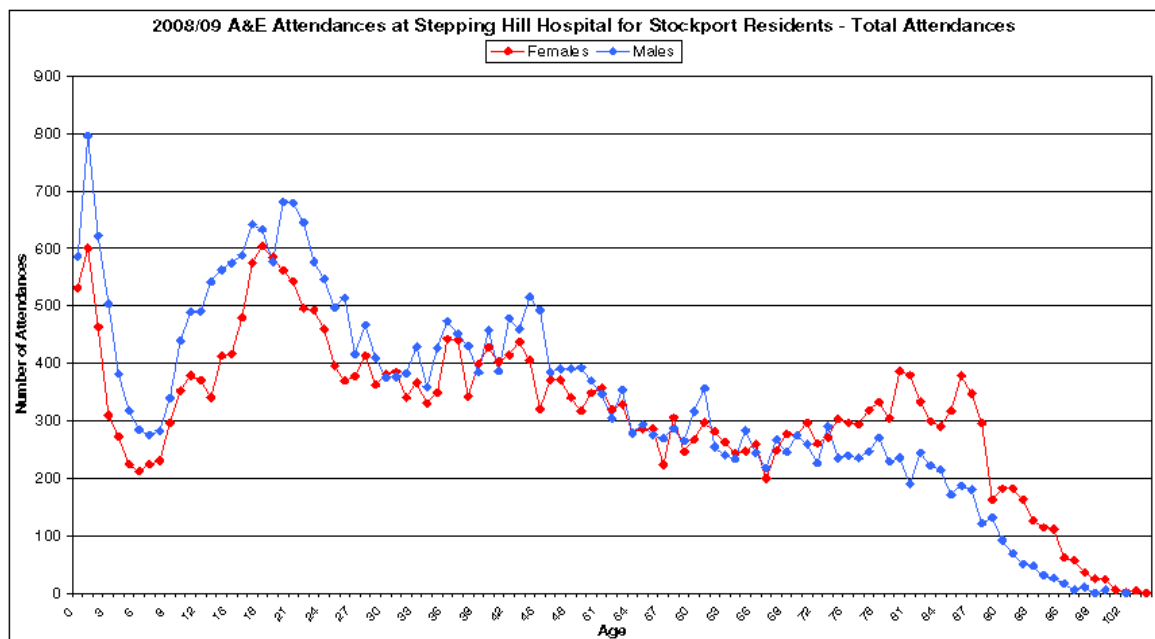
3.5 Disability

The Trust has recently begun to collect information related to patients who have a disability but can not produce monitoring data as the Patient admission system does not yet have a field to record this information. However, in 2010/11 we can report that British Sign language Interpretation was used for 72 healthcare appointments.

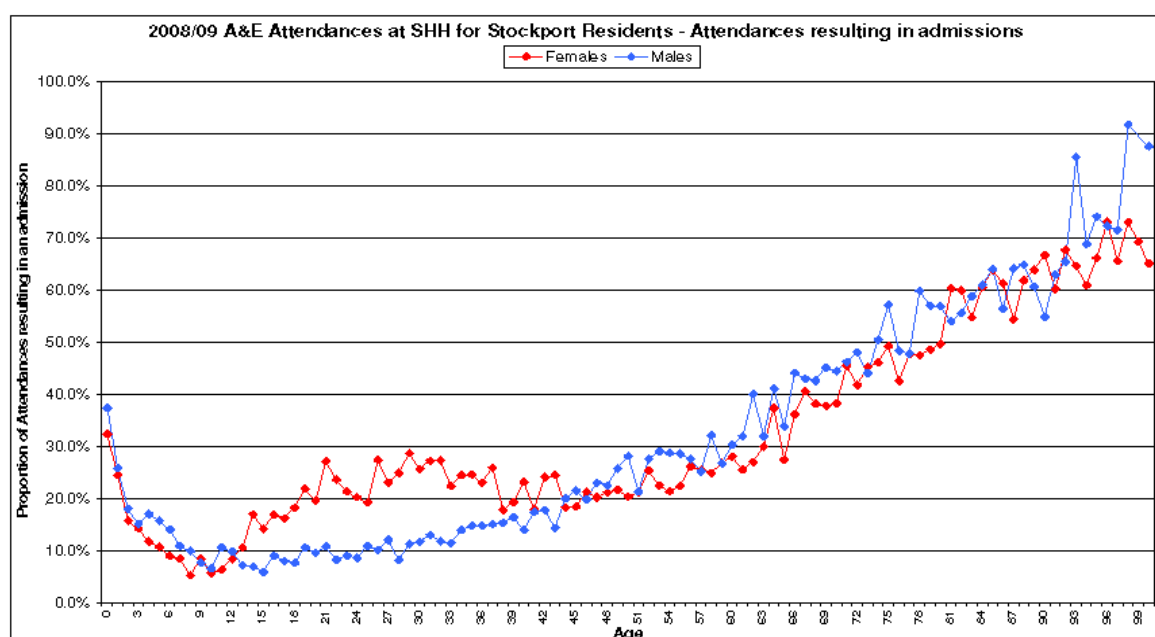
4. Urgent Care

Perhaps as a result of their lower use of primary care services, men are more likely to use emergency health services than women.

Men attend A&E in greater numbers than women between the ages of 0-49 years. The picture is more mixed in age bands 50-79, but women attend in greater numbers past the age of 80 – an effect of lower life expectancy in men.

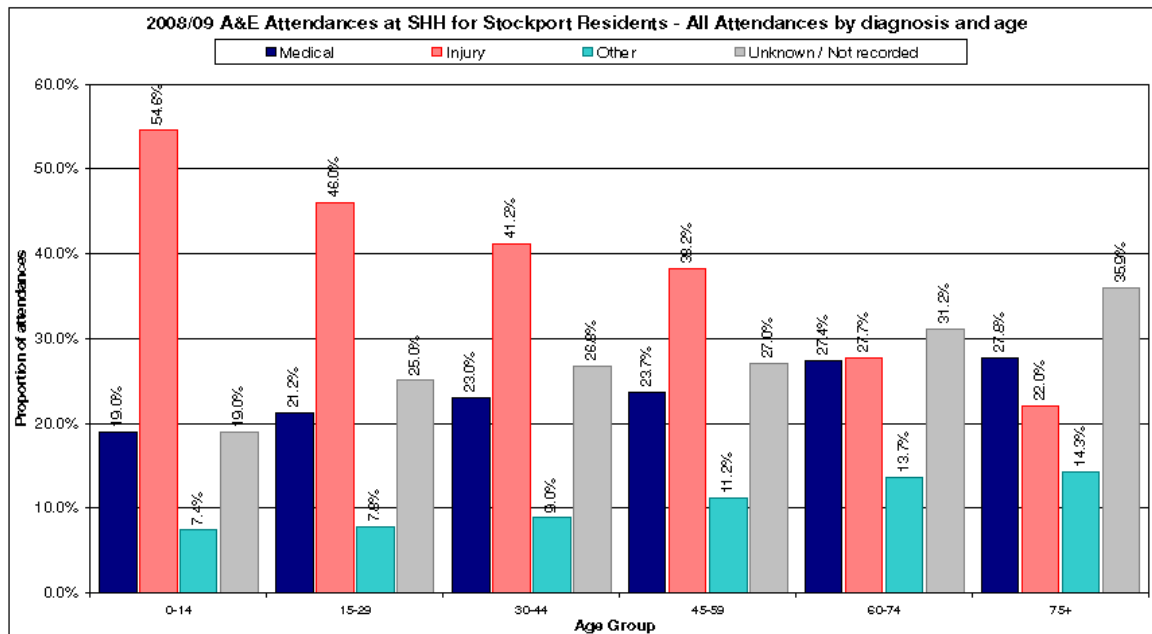


The proportion of A&E attendances resulting in a hospital admission is highest among the elderly, due to increased changes of multiple health problems and complications. There is also a peak in trends at the start of life for similar reasons related to vulnerability and complex conditions.



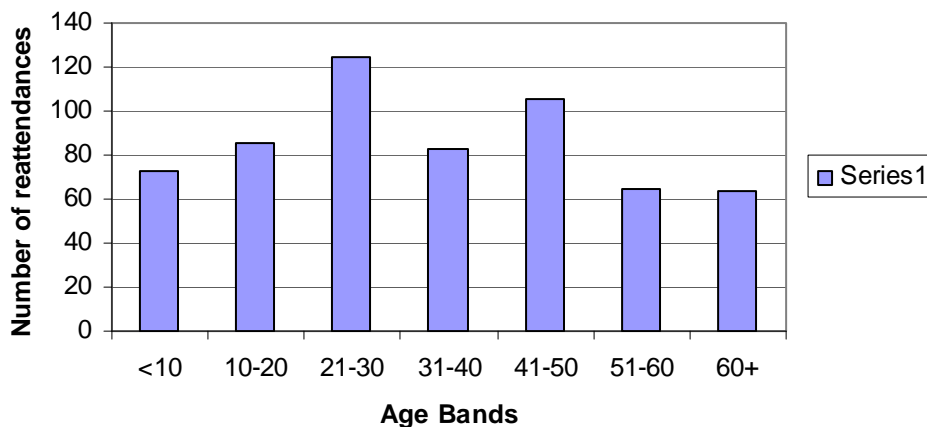
Among 20-40 year olds, there is also a greater propensity for women to be admitted, which relates to increased health needs and complications during pregnancy.

Younger people are more likely to attend A&E due to an injury, while the reverse is true for medical problems, which cause more and more people to go to A&E as they age.

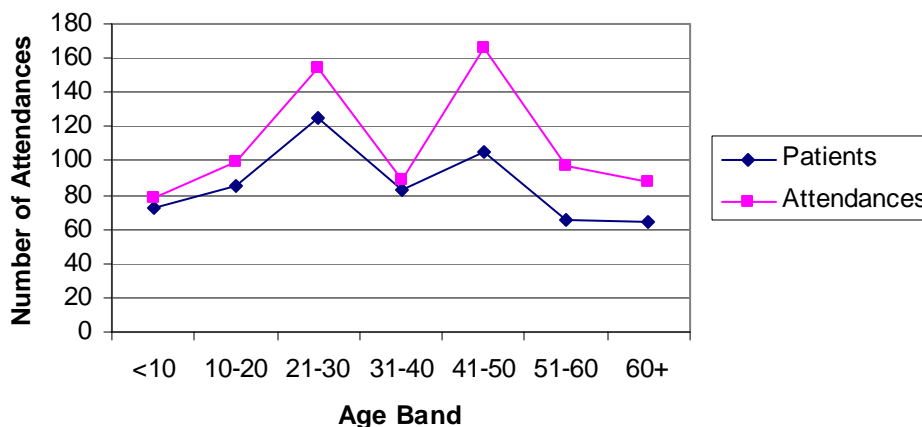


A snapshot of the re-attendance at the Emergency Department by age range shows interesting peaks in the data with the 21-30 age range and the 41-50 showing considerably more episodes. The second graph shows that on a high number of occasions within the 41-50 age range this is due to some patients re-attending more than once.

Reattendance at ED from 1/4/11 to 29/5/11



ED Reattendance



5. Lifestyle Service Team

Current UK health policy emphasises that secondary care needs to change from a 'sickness service' to a 'health driven service' which enables the population as a whole to avoid disease through effective public health measures; and that health promotion for healthy lifestyles is a top priority for the acute sector. All healthcare organisations are required to have in place programmes for health promotion and disease prevention for the whole community with regard to priority areas:-

- Stopping Smoking,
- Obesity
- Alcohol Management Services.

The aim of the service is to ensure that all patients in these areas are assessed for smoking, alcohol use and obesity using valid assessment documents; and that appropriate care pathways are followed and referrals to the relevant lifestyles services are completed according to the patients' needs.

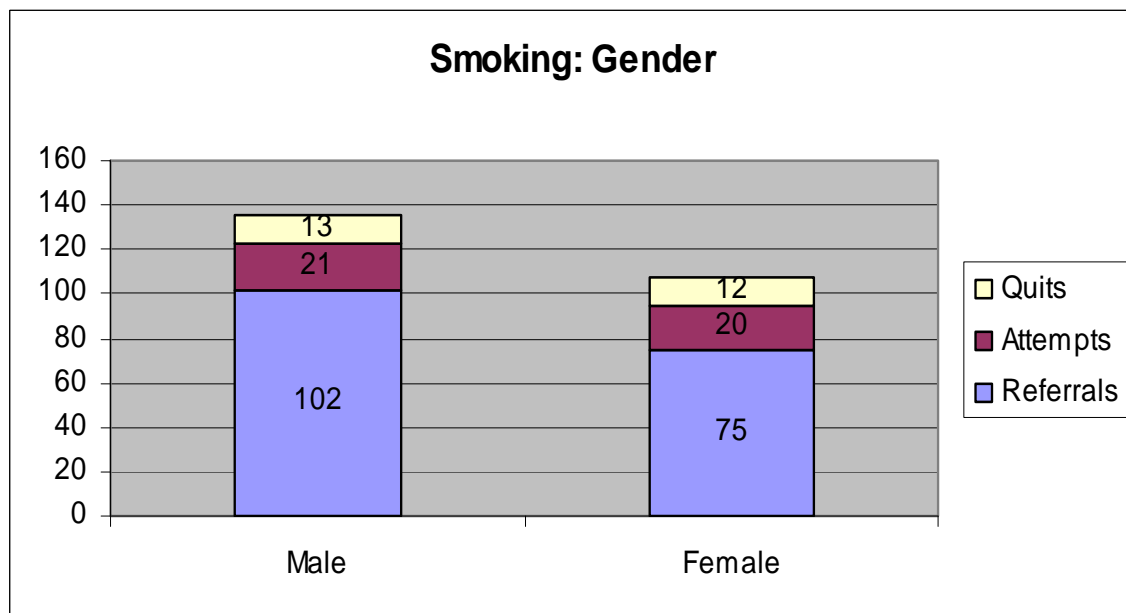
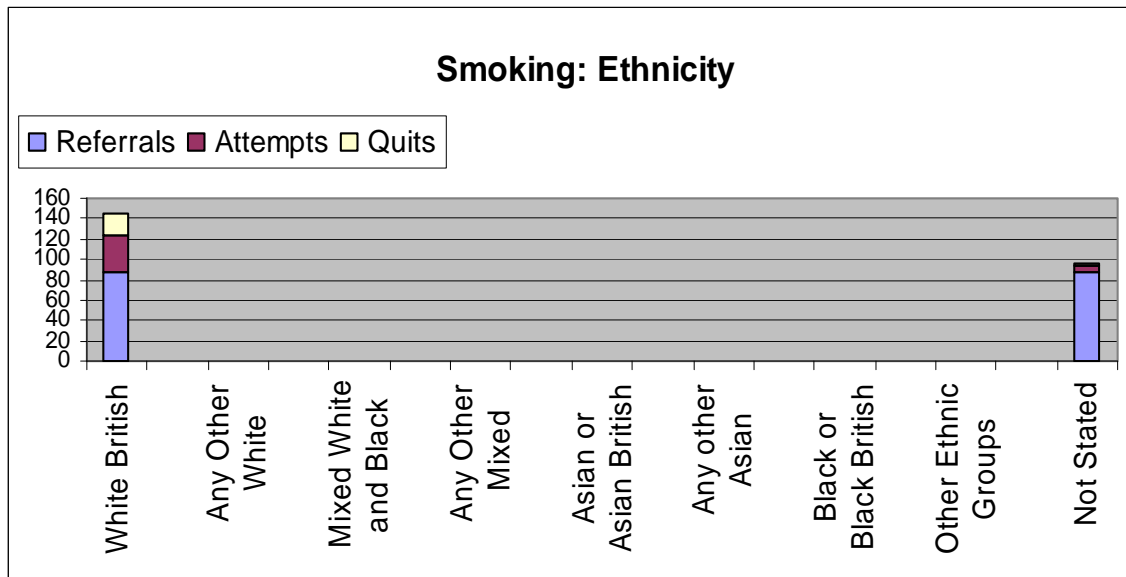
Staff working on the wards have received training and development to enable them to assess patients' lifestyle behaviours and deliver the appropriate health promotion relevant to individual patient needs, in a timely and effective manner.

The following charts show the current available breakdown for patient's access in these services from April 2010 to March 2011.

Smoking

Smoking is the highest preventable cause of death in the UK and key determinant of health inequalities in the borough. National statistics suggest that ethnic minority populations and LGBT groups are significantly more likely to smoke than the majority of the population.

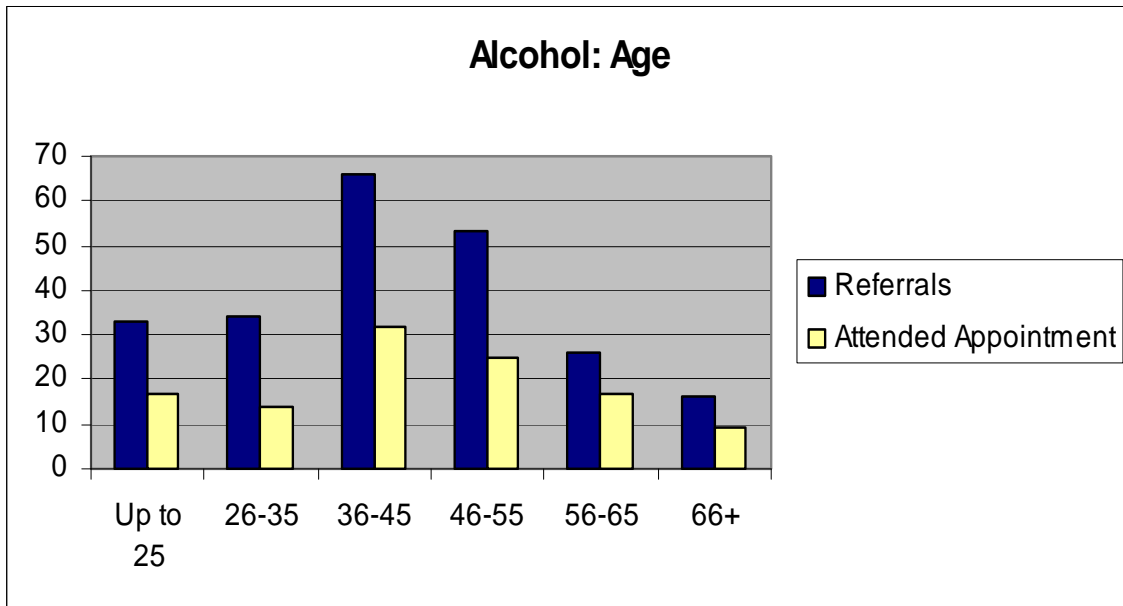
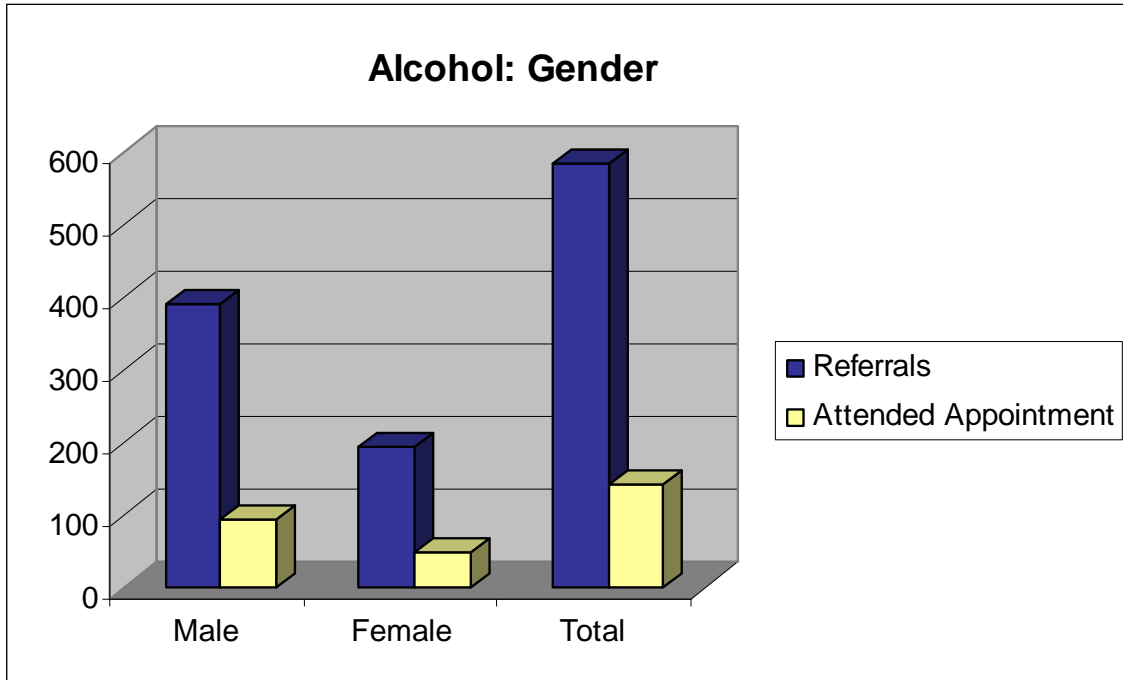
Stepping Hill Hospital's Stop Smoking service received 177 referrals over the period April 2010 – March 2011.

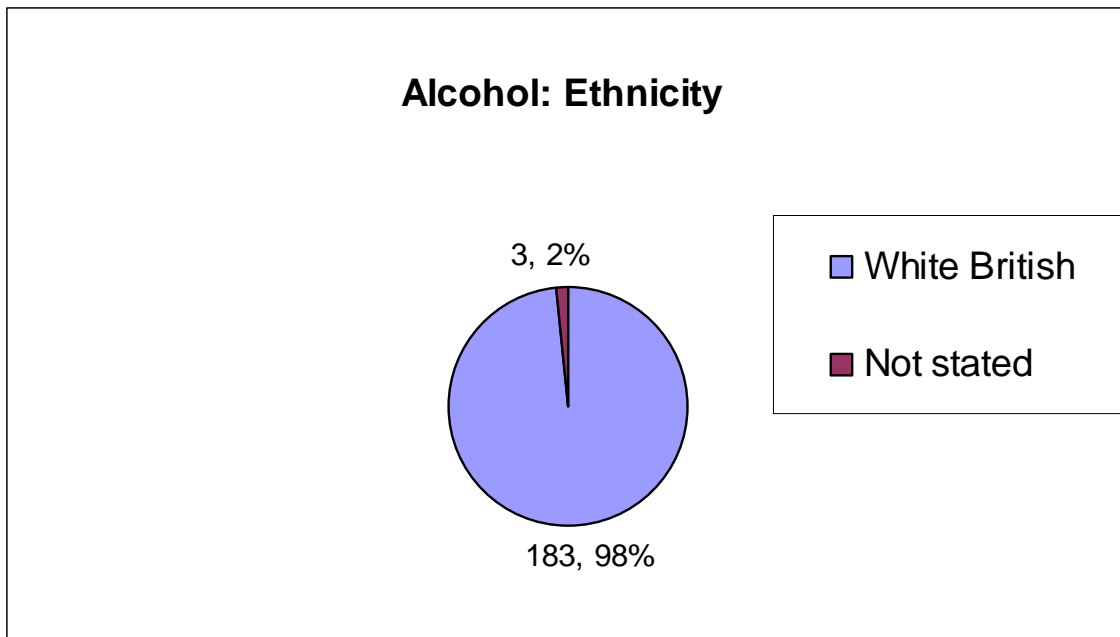


The higher number of men accessing this service reflects the national picture that more men smoke in society. However the fact that all referrals are White British, White Irish or White Any Other Background needs further examination. Even though Stockport has a small BME community it would seem unlikely that none of this group have attempted to access this service. Future engagement with this community should further examine the reasons and any barriers to the service for BME patients.

Alcohol

Over 2010-11, Stepping Hill Hospital's alcohol service received 585 referrals of which only 141 patients attended their appointment.





More men than women referred through this service which is in line with national picture. The absence of BME patients is perhaps to be expected as they are more likely to abstain from alcohol for religious reasons. The fact that 55% of the referrals are under 45 fits with the picture presented in the Joint Strategic Needs Assessment for Stockport where this is described as an alcohol “epidemic” within the younger residents. Alcohol related admissions are one of the largest elements of increasing hospital admissions which in turn is one of the greatest pressures on NHS resources.

The high numbers of drop out from referral to attending is a concern and is being addressed to a small extent by heightening staff awareness and training within the Emergency Department. However the Alcohol Health Advice Service it has nearly tripled the number of people supported during the year, thanks to partnership working with the Hospital’s Emergency Department.

6. Women and Children’s

The Office for National Statistics reports that fertility rates in England and Wales rose from 113.1 births per thousand females aged 30–34 in 2009, to 117.8 in 2010. This has been the trend for the last two decades, during which the number of live births to mothers aged 40 and over has nearly trebled from 9,717 in 1990, to 27,731 in 2010.

The standardised average (mean) age of mother has risen from 29.4 years in 2009 to 29.5 years in 2010, compared with 28.5 years in 2000. These trends reflect the increasing number of women who have postponed childbearing to a later age. This may be due to a number of things such as increased participation in higher education, establishing a career, getting on the 'housing ladder' and ensuring financial stability before starting a family.

The number of live births in 2010 increased for all ages except women aged under 20 compared with 2009.

Annual changes in the size and age-structure of the female population aged 15-44 are driven by migration, mortality, the number of women entering the key childbearing ages (those turning 15 years of age) and the number of women exiting the key childbearing ages (those reaching age 45).

Stockport's birth rate had decreased steadily to 2003; however since then the rate has increased. Projections suggest that in the future the numbers of births in Stockport will stabilise at the higher level. Birth rates are highest in the most deprived areas, in the Brinnington priority 1 area fertility rates are 50% higher than average; and in BME communities.

There were 4118 live births at Stepping Hill Hospital between 1st April 2010 and 31st March 2011.

Age range of mothers April 2010 – March 2011

Age Range	Number of live births	% Live Births
<16	1	0.02
16-24	868	21.08
25-34	2310	56.1
35-44	932	22.63
45-54	7	0.17
55-64	0	0
65+	0	0
Total	4118	100

The number of births peaks within the 25-34 age range which is in line with the 29.5% average age for giving birth. Within the 16-24 age group 178 (4.3%) of the mothers were under the age of 20 and within the 35-44 age group 164 (18%) were age 40 to 44. Within the 7 births to mothers in the 45-54 age range, 47 was the oldest age recorded.

Ethnicity of mothers April 2010 – March 2011

Ethnicity	Number of births	% of births	Stockport residents 2001 Census
White			
British	3531	85.74	92.9%
Irish	9	0.22	1.5%
Any other White background	87	2.11	1.3%
Asian or Asian British			
Bangladeshi	2	0.3	0.1%

Indian	34	0.83	0.7%
Pakistani	62	1.51	1.0%
Any other Asian background	35	0.85	0.3%
Black or Black British			
African	12	0.29	0.1%
Caribbean	5	0.12	0.2%
Any other Black background	5	0.12	0.1%
Mixed			
White & Asian	2	0.05	0.3%
White & Black African	5	0.12	0.1%
White & Black Caribbean	10	0.24	0.3%
Any other mixed background	10	0.24	0.1%
Other Ethnic Group			
Chinese	23	0.56	0.4%
Any other Ethnic Group	27	0.66	0.1%
Not disclosed	261	6.34	0%

The ethnic makeup of mothers giving birth seems quite reflective of the community population data with a slightly higher representation within the Asian or Asian British ethnic group compared to the Stockport residents figure. However the census data does not indicate the gender make-up for these groups and therefore if the gender makeup is 50/50 male and female then the live birth data compared to Stockport residents by ethnic group shows higher representation than expected. The analysis of birth and school census data indicates that Stockport is becoming more diverse and therefore this trend will continue. The 0-15 age group is the most ethnically diverse group in Stockport and this will have obvious implications for future statistics around live births.

Areas to the west of the borough have the highest proportions of younger population from BME ancestries; in Cheadle & Gatley ward a third of births where ethnicity is known were for babies of a BME ancestry. However, mothers from this borough may access Wythenshawe and Manchester Royal Infirmary as well as Stepping Hill Maternity Service.

Religion or belief of mothers April 2010 – March 2011

Religion or Belief	Number of mothers	% of mothers
Greek Orthodox	2	0.05
Evangelical	3	0.07
Congregationalist	1	0.02
Church of England	1368	33.22
Christian Scientist	1	0.02
Christian	296	7.19
Baptist	2	0.05

Buddhist	11	0.27
Jehovahs Witness	11	0.27
Jewish	6	0.15
Methodist	53	1.29
Mormon	3	0.07
Muslim	101	2.45
No Religion	984	23.9
Not on list	23	0.56
Orthodox Jew	1	0.02
Pentecostal	3	0.07
Presbyterian	1	0.02
Roman Catholic	520	12.63
Salvation Army	1	0.02
Sikh	6	0.15
Unitarian	1	0.02
United Reform Church	3	0.07
Unknown	697	16.93
Total	4118	100.00

Again when the number of patients from all denominations of Christianity are considered the overall figure is around 50% and with just over 40% either no religion or unknown this accounts for 90% of the mothers giving birth, therefore again these indicative figures would suggest that access to hospital services is reasonably reflective of the local population.

7. Chest Clinic April 2010 to February 2011

People from all ethnic groups are affected by Chronic Obstructive Pulmonary Disease (COPD). Whilst there are no reliable estimates for the number of people with COPD in minority ethnic groups, given that 85% of COPD is related to smoking, Health Survey England 2004 figures would suggest that Bangladeshi men (40% smoking prevalence) are most at risk, followed by men who are Irish (30%), Pakistani (29%), Black Caribbean (25%), Black African and Chinese (21%), or Indian (20%).

Amongst women, the figures are high for Irish (26%) and Black Caribbean (24%) women, dropping significantly for Black African (10%), Chinese (8%), Indian and Pakistani (5%) and Bangladeshi (2%) women.

However, the overall number of people from ethnic minorities with COPD, and their proportion as a whole, is expected to rise with the aging of ethnic minority populations.

The ethnicity of chest clinic patients shows some representation from these high risk groups:

Ethnicity	Out-patients 2010/11	Chest Clinic Patients	Stockport residents 2001
White:			
British	82.3%	82.7%	92.9%
Irish	0.9%	1.2%	1.5%
Other White	2.2%	1.7%	1.3%
Mixed:			
White/Black Caribbean	0.1%	0.02%	0.3%
White/Black African	0.1%	0.1%	0.1%
White/ Asian	0.1%	0.1%	0.3%
Other Mixed	0.2%		0.1%
Asian/ Asian			
British:			
Indian	0.5%	0.6%	0.7%
Pakistani	0.9%	0.8%	1.0%
Bangladeshi	0.2%	0.02%	0.1%
Other Asian	0.3%	0.3%	0.3%
Black/ Black			
British:			
Black/ Black Caribbean	0.1%	0.1%	0.2%
African	0.2%	0.1%	0.1%
Other Black	0.1%	0.1%	0.1%
Other:			
Chinese	0.3%	0.1%	0.4%
Other Ethnicity	0.3%	0.3%	0.1%
Total BME*	3.4%		3.8%
Total BME + WME*	6.5%		6.6%
Not given	6.0%	11.7%	0%

Religion	Grand Total
Salvation Army	4
Baptist	12
Buddhist	10
Christian	166
Church of England	3055
Congregationalist	5
Evangelical	4
Greek Orthodox	2
Hindu	27
Jewish	6
Jehovah's Witness	18
Methodist	250
Muslim	76
No Religion	437
Not on list	52
Plymouth Brethren	1
Pentecostal	3
Presbyterian	4
Roman catholic	862
Church of Scotland	24
Unknown	419
Unitarian	8
United Reform Church	24
Total	5469

There are differences in the incidence of COPD according to sex. COPD has, certainly until recent years, disproportionately affected men (because of sex differences in smoking and employment in industries that may expose the individual to risk, such as coal mining).

In the UK, the rate of lung disease has been increasing nearly three times faster amongst women than men. Women are more susceptible to developing lung disease than men, also because their lung function worsens with lesser duration of smoking or intensity of smoking than that of men.

Recent figures show that chronic lung disease (predominantly COPD) is the primary cause of death for a higher proportion of men than women. It accounts for almost 5.5% of all deaths in men, and just over 4.5% in women.

The chest clinic monitoring data reflects this trend with 52% male and 48% female patients using the service.

Sex	Number of Patients
Female	2625
Male	2844
Grand Total	5469

COPD is a progressive disease, linked to smoking in around 80% of cases, and the older you are, and the more you have smoked, the worse your COPD will become. It primarily affects people over the age of 45.

The monitoring figures for Chest Clinic patients reflects this pattern:

Age range	Number of Patients	Percentage of Patients
<16	0	0%
16-24	120	2.3%
25-34	184	3.4%
35-44	281	5.1%
45-54	608	11.1%
55-64	1167	21.3%
65+	3109	56.8%
Total	5469	100%

8. Patient Experience Questionnaires

8.1 Inpatient Survey 2010

The inpatient survey is sent to a sample of patients discharged from the Trust during July, August or September. This counts back consecutively from the last day of the month until they reach 850 patients. The month of sample was August for the 2010 survey, 831 patients were eligible for the survey, of which 373 returned a completed questionnaire.

The results for the Inpatient Survey 2010 were broken down by age, gender and disability (long-standing condition) however Picker were unable to produce a breakdown by ethnicity or religion due to the low numbers of respondents in many of the categories. The sexual orientation of patients is not recorded as part of the inpatient survey. Also the results tables for disability do not show results where there were fewer than 10 respondents in the category. This is to protect the confidentiality of respondents.

Gender

Contrary to the outpatients survey the gender analysis of the inpatient survey shows far fewer differences in levels of patient satisfaction. Male patients are less likely to feel they have been offered a choice of hospitals and an explanation of why they had to wait for a bed. Although 74% of patients have responded that they have trust in the nursing staff, of the minority who didn't respond positively female patients felt this more strongly. Female patients were also more likely to feel that staff contradicted each other.

Age

The age analysis suggests that the 40-59 age range are less satisfied with the service but the data is difficult to interpret because of the low response rate in some age ranges. The 40-59 age range are less likely to think that doctors knew enough about their condition and 54% felt that results were not explained in a way that could be understood.

The number of patients receiving printed information about the hospital varies vastly across the age ranges, from 82.9% receiving information in the 60-69 group down to 50% in the 16-39 group. The number of minutes wait after using the call button also varied across the age ranges and in the 80 and over age range 25% said they had waited longer than 5 minutes.

Over 30% of the 80 and over age range also recorded that they were less likely to be told how they would feel after they had had the operation or procedure and 50% of the delays at discharge for this age group were due to a wait for an ambulance. Interestingly question J11 highlights that the 16-39 age group are more likely to be extremely anxious or depressed than the other age groups.

Disability

In common with the outpatient survey the inpatient survey broken down by long standing condition/ disability does not show representation from patients who are blind/partially sighted, have a learning disability or a mental health condition. However a number of issues are highlighted for patients with a long standing physical condition:-

- Less likely to have confidence and trust in nursing staff and didn't feel they were always given clear answers to questions.
- Less likely to feel they had been treated with dignity and respect.

Just over 60% of these patients did not have an operation or procedure, are 65.5% females and 75% have some problems in walking around. Over 40% have some problems washing or dressing themselves, 28.1% recorded that they have extreme pain or discomfort and 71.9% said their condition causes difficulty with everyday activities that people their age can usually do.

8.2 Outpatient Survey 2011

The Outpatient survey 2011 is based on a random sample of outpatients who attended an appointment during April 2011. The purpose of the survey is to understand what outpatients think of healthcare services provided by the Trust. All trusts used a standard survey methodology and standard questions, as specified by the Co-ordination Centre for the NHS Patient Survey Programme, based at Picker Institute Europe. The questionnaire reflects the priorities and concerns of patients and is based upon what is most important from the patient's perspective. The questionnaire was developed through consultation with patients, clinicians and trusts.

The survey was undertaken by a postal questionnaire, sent to patients' home addresses. Patients were sent a questionnaire, a covering letter from the Trust's Chief Executive, a multiple language sheet offering help with the survey, and a freepost envelope. Patients wishing to complete the survey filled it in and returned it to the Picker Institute in the freepost envelope. Non-responders were sent a reminder card after 2 weeks and another questionnaire after a further 2 weeks. The Picker Institute ran a freephone helpline for patients who had any queries or concerns about the survey. This included links to Languageline with immediate access to interpreters in over 100 languages.

A total of 850 outpatients from Stockport NHS Foundation Trust were sent a questionnaire of which 394 returned a completed questionnaire, giving a response rate of 47%. The average response rate for the 74 'Picker' trusts was 49%.

Our results

- 92% of patients reported their overall rating of care as good, very good or excellent.
- 88% of outpatients were treated with respect and dignity all of the time at the Outpatients Department.
- 85% of respondents were definitely given enough privacy when discussing their condition or treatment.
- 80% definitely had confidence and trust in the doctor examining and treating them.
- 71% of patients were definitely involved as much as they wanted to be in decisions about their care and treatment.

Most patients are highly appreciative of the care they receive. However, it is evident that there is also room for improving the outpatient experience. Picker Institute Europe uses a simple summary score to show you where patients think there is a problem or room for improvement regarding a specific aspect of care.

There were too few (8) non-white respondents to break down results by ethnicity and questions on religion and sexual orientation are not asked on the outpatient survey so this breakdown is unavailable also.

Gender

The problem scores disaggregated by gender shows that in most cases female patients are less content with the outpatient service than male patients. For example question F7 shows that 13% of males did not have full confidence and trust in the doctor, relative to 23% of females. They were less likely to have received explanations and the risks/ benefits involved or how the treatment had gone. The only area highlighted by male patients was not being told about the side effects of the medication.

Although slightly more females than males responded to the survey this does not skew the data because the % of male and female respondents (46% and 54% respectively) is identical to the % of males and females that were in your original sample of 850 patients. This was a random sample of outpatients taken across a month, therefore the % of male/female respondents is representative of the patient population.

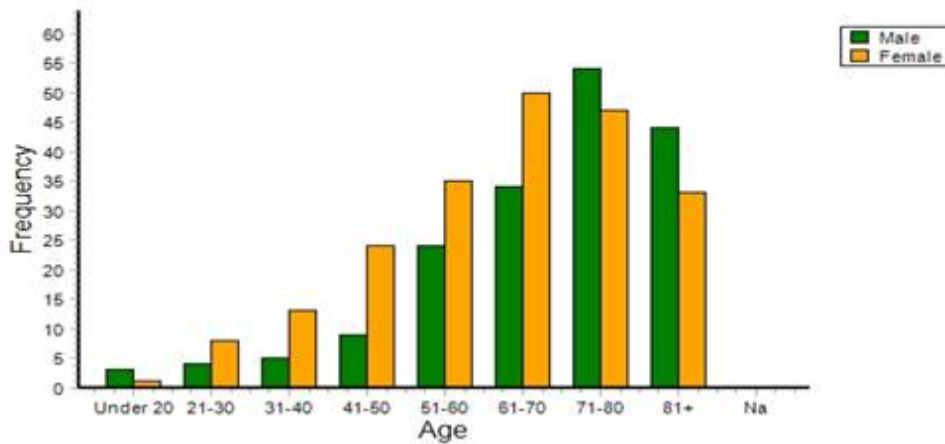
Age

The problem scores disaggregated by age ranges shows a low number of respondents to some questions and therefore it is difficult to compare the results. However where there are responses a number of patterns are highlighted:-

- Although only a small percentage of patients (5%) recorded care as fair or poor the 16-39 age range were slightly less happy with the care received, found it harder to find the Outpatients Department and their appointments were more likely to start more than 15 minutes after stated time. They were more likely to feel that staff contradicted each other and would have liked more information about their condition.
- The 50-59 age range felt that the doctor did not know enough about the medical history and did not give clear answers to questions.
- The 80+ age range are less likely to get leaflets about hand washing and suggest that hand gels were not available. They also felt that staff did not clearly explain test results and needed more time to fully discuss health problems.

However when considering these points it is important to consider the gender split by age range e.g. in the 16-39 age range the gender split is 65% female.

- 45% of survey respondents were male and 54% were female (2% did not answer). The age range of male and female patients is shown in the graph below:



Disability

Picker do not breakdown the results for categories with fewer than 30 respondents. Therefore the problem scores have been broken down by disability against no disability but because of the low response rate this does not include representation from patients who have a learning disability, mental health condition or are blind/partially sighted. The following question was asked in the outpatient survey. The disability question is a ‘tick all that apply’ question so that a patient is able to record more than 1 disability.

L3 - Do you have any of the following long-standing conditions?

All Patients	n	%
Deafness or severe hearing impairment	51	12.9
Blindness or partially sighted	27	6.9
A long-standing physical condition	97	24.6
A learning disability	3	0.8
A mental health condition	7	1.8
A long-standing illness, such as cancer, HIV, diabetes, chronic heart disease, or epilepsy	106	26.9
No, I do not have a long-standing condition	146	37.1
Not answered	28	7.1
(Total number of respondents)	394	

The results that compare disability against non-disabled are very mixed. Whilst those with a disability were less likely to be fully aware of what would happen during the appointment and have their appointment starting 15 minutes after the stated time they were however more likely to be told how the treatment had gone and have time to discuss health problems. Those with a disability felt more strongly that staff did not clearly explain test results and the risk/ benefits but those without a disability felt

that the doctor didn't give clear answers and were less likely to discuss worries or fears with the doctor.

Question J3 to J5 indicate a lack of confidence in medication provided but this is significantly higher for those outpatients without a disability. Although those with a disability felt more strongly about the reason for changing medication not being explained sufficiently.

The overall satisfaction measured in K1 to K5 questions indicates slightly less satisfaction for outpatients who have a disability.

In conclusion these results demonstrate the value of additional data analysis when undertaking a patient survey and how the results can be heavily influenced by the number and diversity of respondents. The lack of data around ethnicity, religion, sexual orientation is disappointing, as is the breakdown of data around disability with no representation from patients who are blind/ partially sighted, have a learning disability or a mental health condition. Therefore this report will recommend as a priority further engagement with the Picker Institute to look at ways to encourage better representative sampling.

There are some themes from the existing data that are worthy of further examination now and should help to target improvements in the areas where they are needed most. These are:-

Inpatient

- Further investigate the apparent difference in services for the 40-59 age group. This may involve additional survey questions or possibly a team meeting to address the issues raised by the picker results.
- Audit procedures to ensure that the printed information about the hospital does not vary across age ranges.
- Investigate the use of the call button for patients 80 and over, why this group are less likely to feel prepared about how they would feel after they have had a procedure and also why the delays at discharge for this age group are mainly due to a wait for an ambulance.
- Investigate the issues that are highlighted for patients with a long standing physical conditions including why they are less likely to have confidence and trust in nursing staff and are less likely to feel they have been treated with dignity and respect.

Outpatient

- Further local survey to better understand the difference in patient experience for female and male outpatients. In particular why they are less likely to have full confidence and trust in the doctor, less likely to have received explanations and the risks/ benefits involved or how the treatment had gone.
- Further investigate the apparent difference in services for the 16-39 age group. This may involve additional survey questions or possibly a team meeting to address the issues raised by the picker results.

- An impact assessment of the outpatient services which involves patients with disabilities would help to address some of the concerns from the survey results. It is particularly important to understand why these patients are less likely to be fully aware of what would happen during the appointment and why they felt that staff did not clearly explain test results and the risk/ benefits.

9. Conclusion/ Recommendations

This report shows that by using equality monitoring data for service users the Trust is able to demonstrate where there is equality of access and where there may be some barriers for protected groups. However whilst our data around ethnicity, age, gender and religion has steadily improved there is a significant gap around the collection of data on disabilities and sexual orientation. A priority action, along with all equality issues, for securing improved outcomes is to institute a system of routine local monitoring of access to services, experience and outcome. In addition the following actions represent a summary from preceding analysis of data:-

- Consider the reasons for peaks in age range data for the Emergency Department re-attendance figures.
- Identify gaps in data and identify inconsistencies to the lifestyle team. Further investigate access to smoking service for BME patients.
- Engage with Picker to encourage better representative sampling.
- Use disaggregated patient experience survey data to explore apparent inequalities.
- Restrict the recording of religion or belief to the census categories.
- Training for frontline staff in the reasons for collecting equality data and how best to ask questions to improve the response rate.

If you would like this policy in a different format, e.g. in large print, or on audiotape, or for people with learning disabilities, please contact Patient and Customer Services.

Your local contact for more information is Patient and Customer Services at Poplar Suite, SHH, Tel: 0161 419 5678 or www.stockport.nhs.uk

A free interpreting service is available if you need help with this information. Please telephone Stockport Interpreting Unit on 0161 477 9000. Email: eds.admin@stockport.gov.uk

如果你需要他人為你解釋這份資料的內容，我們可以提供免費的傳譯服務，請致電 0161 477 9000 史托波特傳譯部。

W przypadku gdybyś potrzebował pomocy odnośnie tej informacji, dostępne są usługi tłumaczeniowe. Prosimy dzwonić do Interpreting Unit pod numer 0161 477 9000.

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اگر آپ کو ان معلومات کے بارے میں مدد کی ضرورت ہے تو مفت ترجمانی کی سروس دستیاب ہے۔ براہ مہربانی انٹرپرائٹنگ یونٹ کو 0161 477 9000 پر فون کریں۔

خدمات ترجمہ رایگان این اطلاعات در صورت نیاز موجود میباشد. لطفاً با شماره تلفن 0161 477 9000 با واحد ترجمہ (اینترپرائٹنگ یونیت) ما تماس بگیرید.

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