National Summary of the Service User Experience Survey 2017

HSE National Social Inclusion Office

HSE National Addiction Advisory Governance Group

2018

Contents

Summary and Recommendations

Summary

In brief, the following is a summary of the quantitative findings nationally:

Strengths

- A clear and welcome finding from all reports was that staff were reported to be kind, supportive, non-judgemental and welcoming, in particular counselling staff, project staff, nursing staff and security staff.
- The majority of respondents across all areas felt they had been given enough information on peer support groups.
- The services were reported as being flexible and understanding, particularly with regard to missed appointments due to court appearances or relapse.
- When asked if they felt involved in their care plan, an average of 89% of respondents said they felt involved in their care plan. This is with the exception of the services in one area, which had a lower response of 63%.
- Respondents reported feeling safe in terms of their health, privacy and confidentiality in the service. Mental health concerns were addressed for some respondents.
- Overall, on average 86% of people reported having signed a consent form. This is with the exception of one area, where just over half the respondents (n=22) indicated they were asked to sign a consent form.
- Across all areas, the vast majority of respondents indicated that they feel they are treated like an equal, they feel safe, they feel they are listened to and are communicated with in an appropriate fashion.
- Between 81% and 98% of respondents felt they were respected as an individual, supported to maintain their dignity and were given privacy if they wanted it.
- The vast majority of people surveyed said they felt they were welcomed in the service in relation to their gender, marital status, family status, age, race, religion, disability, sexual orientation or membership of the Traveller community.
- Between 79% and 97% of respondents across all services surveyed said they would recommend the service to a friend or family member.

Weaknesses

- Up to a quarter of respondents in some areas said the treatment service offered was not their first choice. Respondents reported that more treatment options could be available to them, including interventions specific to mental health and sexual health. Some reported they would like to be prescribed Suboxone (an alternate to Methadone for Opioid Substitution Treatment). The lack of options for moving on from the service was also named.
- Access to the service was cited as a weakness. Long waiting lists and the geographical spread of services, particularly in rural areas were reported to be the reason for this finding.
- A significant finding from both the question about cost and the qualitative responses was that approximately half the respondents did not have any information on the cost of the service, ie they did not know the service was free. This could be a potential barrier to access the service initially.
- In some areas just over a quarter (N=17, N=8) of respondents reported receiving encouragement to make positive changes to their sexual health behaviours.

- The results relating to complaints indicated not all people were aware of how to make a complaint. As little as a quarter (n=15, n=31) of those surveyed in two CHO areas reported a knowledge in this area.

Recommendations

Preferred Treatment: Revise the questionnaire to include a qualitative section for respondents who answered no to the question on if the treatment was their preferred choice.

Complaint Handling: Revise the questionnaire to include a question if the respondent has ever made a complaint. If the answer is yes, was the person satisfied with how the complaint was handled. Review the complaints procedures in services. Do the people using the services know how to make a complaint? Do the staff know how to respond to a complaint? How are complaints and the resolution of complaints followed up and communicated on? This may require a staff survey.

Access to services in rural or remote areas: Further investigation warranted. The long travel times, reliance on public transport and the associated cost, along with long waiting list were raised as barriers to accessing services for some respondents. Some suggestions from the people using the services were to consider a mobile clinic for remotes rural areas, consider 'take-out's and consider providing people with monthly bus passes.

Sexual Health: Opportunities and methods to discuss sexual health with service users, including training needs analysis, could be explored further.

Survey design: Revise the questionnaire to include a qualitative section on the preferred treatment for respondents who answered no to the question on if the treatment was their preferred choice. Revise the questionnaire to include a question if the respondent has ever made a complaint. If the answer is yes, was the person satisfied with how the complaint was handled.

Results: CHOs could analyse their findings locally and develop a quality improvement plan based on the results of this survey. The results of this survey should be communicated to the people who use the services and work in the services. This can be done in a number of ways including through notice board in clinics, newsletter and service meetings.

Reporting: Template for the reporting of findings to be developed in order to maintain consistency in reporting methods, limitations, results, analysis and quality improvement actions.

Background

Introduction

There is a growing interest in measuring and understanding Service User experience in healthcare. Countries all over the world are capturing the quality of care as perceived by their Service Users, due to the increasing evidence linking Service User experience to other important clinical outcomes (Doyle et al, 2013). The literature reviewed supports the fact that there is a correlation between Service User experience, quality of care and care outcomes. Measuring Service User experience is a realistic way to provide opportunities for improvement, enhance strategic decision making, reduce cost, meet Service Users expectations, frame strategies, monitor healthcare performance and provide benchmarking across the health care institutions (LaVela, 2014).

Recommendations from literature synthesis for Service User Experience Tool design

Immediate

- Agree a definition for Service User experience.
- Recommend an agreed framework for Service User experience.
- Recommend that the tool be developed based on currently identified indicators of Service User experience as already available through the research base.
- Recommend full validation process for Tool after first use.

Future

- Encourage real time feedback and mixed ways of gathering Service User experience.
- Recommend a National Framework for Service User Experience to support the current. National Healthcare Charter.

There are numerous satisfaction surveys in the field and many questionnaires developed to gather Service User evaluations. However the design of experience tools is in its infancy. It is accepted that to measure Service User experience we need standards, indicators and mechanisms to measure these constructs. The literature review can be found in Appendix 3.

For Service User experience information to be used effectively within an organisation, the organisation needs to be prepared to change. The National Health Service England (NHS) (2015) warn that this is not a "tick box" exercise and state that if an organisation is going to embrace the idea of working with Service Users as partners in the re-design of services to improve Service User experience it will require fully engaged leaders to support the required culture change.

Rationale for the survey

The Health Service Executive (HSE)(2015) state that quality and safety is to be at the heart of everything we do, we must understand it from the perspective of the people who use our services. Over the past 20 years, Service User feedback has gained increasing attention as a meaningful and essential source of information for identifying gaps and developing an effective action plan for quality improvement (Al-Abri, 2014). It is noted that in some countries, Service User experience surveys are mandatory, namely France and Germany. However according to one report (Grimes, 2003) it is an area where much had been identified, but little has been standardised. The then Minister for Health, Leo Varadkar in 2015 stated that "unfortunately there are no standardised Service User experience surveys across the health sector," and he went on to request the Department of Health (DOH) and the HSE to address this gap (National Healthcare Quality Reporting System (NHQRS) Ministerial foreword First Report, 2015).

The Department of Health (DoH) and the HSE have endorsed and proposed the use of Service User feedback. 'The Your Service Your Say' campaign has been the leading vehicle for Service User feedback in the HSE (HSE, 2017). However, it appears that there is room for services themselves to be innovative in engaging Service Users and understanding Service Users perception of their care. There are a number of quantitative and qualitative methods available on how best to garner Service User feedback such as, Service User satisfaction surveys, focus group, and analysis of complaints. The challenge for the HSE Addiction Services was to devise the best process on how to gather the experiences of the people who use our services, introduce a standard tool applicable to all HSE Addiction Services and devise a project plan for implementation. It is hoped that when the tool is embedded in services, it will lead to continual quality improvement and form a basis for policy development.

Organisational & Policy Context

Organisational

The HSE Addiction Service is under the Social Inclusion Directorate within the Primary Care Services and is responsible for the governance, co-ordination and service provision of addiction treatment across Ireland. There is an effort from a national perspective to standardise referral pathways, increase treatment provision and improve clinical governance in line with the National Drug Rehabilitation Framework (2010 & 2011) and the National Standards for Safer Better Healthcare (NSSBHC)(2012). Services are delivered through the 9 Community Health Organisation (CHO) areas and 24 local drug and alcohol task forces for Tier 3 (specialist services) and Tier 4 (residential treatment).

The National Social Inclusion Office established the National Addiction Advisory Governance Group (NAAGG). Membership of NAAGG includes HSE Operational Managers responsible for the provision of addiction services throughout the country, Social Inclusion Specialists and the National Rehabilitation Coordinator. The overall aim of the NAAGG is to proactively identify issues that impact on the efficient and effective provision of addiction services nationally and develop a consistent response that supports the delivery of quality services and complies with best practice. The NAAGG advises on governance issues that arise and informs decision making of other fora, including the National Social Inclusion Governance Group. A major piece of work in 2016 for the National Social Inclusion Office and NAAGG was the implementation of the National Standards for Safer Better Health Care (2012) as the overarching framework for quality standards for addiction services.

Policy

In 2001, the Governments Health Strategy Quality and Fairness: a health service for you (Department of Health & Children, 2001) promoted the use of Service User satisfaction surveys as one method of including Service Users in the planning and delivery of healthcare. Over the past 15 years, the health service has promoted Service User involvement and Service User feedback as a key driver for quality improvement. On this a range of documents have been developed including the National Strategy for Service User Involvement (2008-2013), the National Healthcare Charter (2008) and The NSSBHC (2012).

Reducing Harm Supporting Recovery: A health-led response to drug and alcohol use in Ireland in 2017 – 2025 (2017) is the current national drug strategy under the Department of Health. Objective 4.2 is to "Enable participation of both users of services and their families" (2017, p.66). Strategic action 4.2.44 specifically states

> Promote the participation of service users and their families, including those in recovery, in local, regional and national decision-making structures and networks in order to facilitate their involvement in the design, planning and development of services and policies.
>
> This is achieved by actively supporting frontline services through capacity building measures using evidence-based models of participation in line with best practice.
>
> (Department of Health, 2017, p. 68)

Methodology

Questionnaire Development

The literature review (appendix 3) assisted in the questionnaire development and an audit was conducted of the types of tools currently being used across Addiction Services in Ireland. These were largely specifically developed questionnaires for identifiable service outcomes.

Understanding Service User Experience – what to measure

In designing the questionnaire it was important to understand and agree a definition of the key components of Service User experience. The key domains of Service User experience are outlined in the literature review and a review was conducted of the most frequently used frameworks applied in Service User experience surveys:

- The NHS Service User Experience Framework.
- NICE Service User Experience in Adult NHS quality standards.
- WHO Responsiveness of HC Systems.

In Ireland, the National Healthcare Charter and the NSSBHC Theme 1, (Appendix 4), condensed in Table 1, could easily be mapped in to any of these most commonly used frameworks. There are similarities and overlap between these frameworks and quality standards. The similarity between frameworks and the adaptability of the National Healthcare Charter and Theme 1 of NSSBHC gave an assurance that a consensus already exists as to what constitutes a good Service User experience. The NSSBHC (2012) has been adapted by the HSE as the overarching quality standards for Primary Care and thereby holds the standards that we are to reach.

National Standards for Safer Better Healthcare

The National Standards for Safer Better Healthcare are the quality standards framework developed by Health Information and Quality Authority (HIQA) in 2012. These National Standards apply to all healthcare services (excluding mental health) provided or funded by the HSE including, but not limited to, addiction services.

This survey focuses on two themes from the National Standards: theme 1 and theme 4.

Theme 1 of the National Standards is Person-Centred Care and Support (Appendix 4). According to HIQA (2012):

> *Person-centred care and support places Service Users at the centre of all that the service does. It does this by advocating for the needs of Service Users, protecting their rights, respecting their values, preferences and diversity and actively involving them in the provision of care. Person-centred care and support promotes kindness, consideration and respect for Service Users' dignity, privacy and autonomy.*

Theme 1 Person-Centred Care and Support has six standards:

Standard 1.1	The planning, design and delivery of services are informed by Service Users' identified needs and preferences.
Standard 1.2	Service users have equitable access to healthcare services based on their assessed need.
Standard 1.3	Service users experience healthcare which respects their diversity and protects their rights.
Standard 1.4	Service users are enabled to participate in making informed decisions about their care.
Standard 1.5	Service users' informed consent to care and treatment is obtained in accordance with legislation and best available evidence.
Standard 1.6	Service users' dignity, privacy and autonomy are respected and promoted.

Theme 4 of the National Standards is Better Health and Wellbeing (Appendix 5). According to HIQA (2012):

> *Services providing care and support have a unique opportunity to promote and protect the health and wellbeing of the population served. A high quality, safe and reliable service constantly looks for ways and opportunities to do this.*

Theme 4 Better Health and Wellbeing has one standard:

Standard 4.1: Service users are enabled to participate in making informed decisions about their care

Table 1: Comparison

NICE Quality Statements (2012)	**THEME 1 NSSBHC: Person Centred Care (2012)**	***NHS Framework (2011)**
Q.S *(4) Opportunities to discuss concerns & preferences Q.S (7) Supporting Service User Choice	1.1 Care is informed by Service Users needs & preferences	(1)Respect for Service User-centred values, preferences and expressed needs, inc. dignity, privacy & independence &

		shared decision making.
Q.S (9) Tailoring healthcare to the individual needs	1.2 Equitable access to healthcare services based on assessed needs	(9) Access to care 2. Co-ordination & integration of care
Q.S (1) Respect for the Service User	1.3 Respect for diversity and protects their rights	(1) as above
Q.S (5) Understanding treatment options	1.4 Make informed decisions about their care	(1)
Q.S (6) Shared decision making	1.5 Informed consent to care & treatment	
Q.S (1) Respect for the Service User	1.6 Dignity & autonomy are respected	(1)
Q.S (1) Respect for the Service User	1.7 Culture of kindness consideration &respect	(1)
	1.8 Complaints and concerns are responded to promptly & effectively	
	1.9 Supported to maintain own health & well being	(2)Information, communication & information 8. Transition & continuity

*Quality Statement

*Modified version of the Picker Institute

The National Healthcare Charter (Ireland)

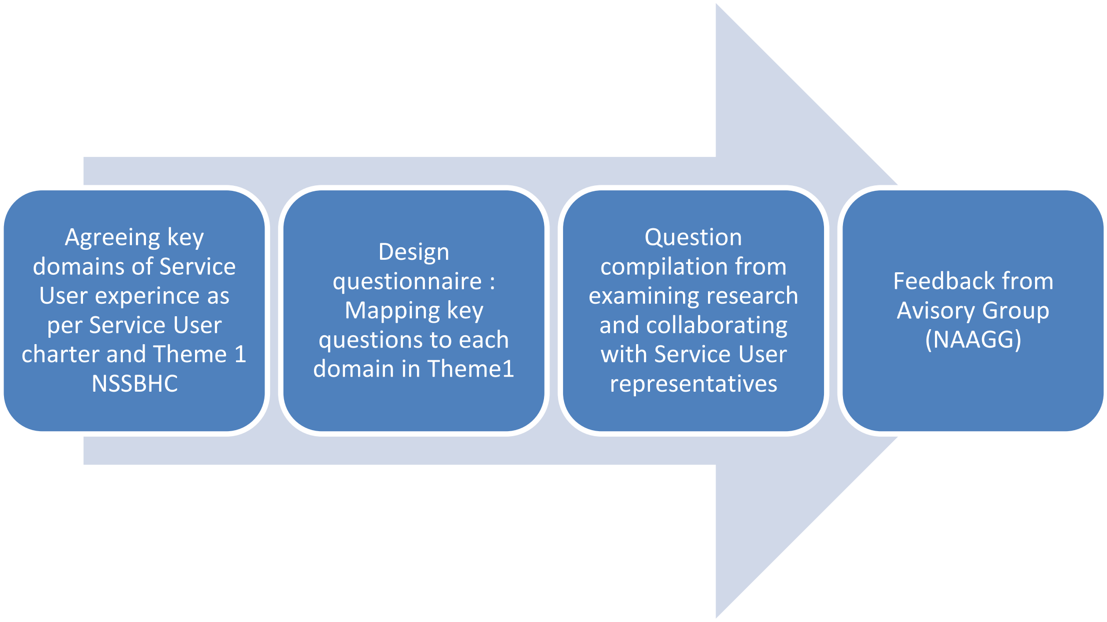
- Access
- Dignity & Respect
- Safe & Effective Services
- Communication & Information
- Participation
- Privacy
- Improving Health
- Accountability

The overall objective was then to establish a limited set of questions, covering the core components of Service User experience. Therefore the questions would be mapped on the National Healthcare Charter and on Theme 1 of the NSSBHC.

Question design through the literature

The process of designing the Service User experience tool comprised of the following key steps:

Figure 1



Questionnaires were identified from all major Service User experience surveys. These mainly originated in the NHS, and some sources from Canada. Particular attention was given to the Service User experience surveys used at a national level in the NHS in the UK as these surveys are developed by organisations expert in this area such as the Picker Institute. A list of questions were compiled for each of the nine domains, and further reduced to four questions per domain. It was also decided to add on demographic questions and included the net promoter question:

> "Would you recommend this service to a friend or family member?"

Complaints and response to complaints and concerns is theme 1.8 of the NSSBHC. However, it was not a question in any of the major current survey tools and is not in the frameworks noted in Table 1 above. It was decided that this was an important domain to measure and one additional question was therefore included for complaints.

The purpose of the survey was to:

1. Provide a baseline of the experience of the people who use our services
2. Inform national service objectives.
3. Assist CHOs to:
    - Inform service planning and identify priorities annually from the perspective of the people who use the services.
    - Identify quality improvements.
4. Enhance involvement from the people who use our services.
5. Enhance staff performance.

Testing the Questionnaire

Prior to the pilot

As this Service User experience tool is for use nationally by all HSE Addiction Services, it was important that the questionnaire was robust therefore the questionnaire was pre-tested via mixed qualitative and quantitative measures. This determined if the questionnaire was fit for purpose from a user perspective and garnered both the user and staff perception before introducing the questionnaire in the pilot sites. The pre-pilot phase also demonstrated question comprehension and highlighted changes that need to be made accordingly. The steps taken prior to going to the pilot phase included: self-administrating the Question Appraisal System (QAS 99), obtaining Service User representative feedback, and consulting with the HSE National Quality Improvement & Safety Division.

CHO 1 self-administered the QAS 99, this questionnaire appraisal system was designed by Willis and Lessler (1999) to assist questionnaire designers in evaluating survey questions and in finding and fixing problems before the questions go to pilot or use. The QAS-99 looks at appraising questions on components under 8 steps:

1) Reading
2) Instructions
3) Clarity
4) Assumptions
5) Knowledge / memory
6) Sensitivity bias
7) Response categories
8) Other

Appendix 6 details the QAS-99 of the final questionnaire. Each question was cross checked against each step above. Using the QAS-99 resulted in question length being modified, language being simplified, and clarity of question was reviewed and improved. It further encouraged us to amend the response categories to three simple choices as opposed to five, with the responses now being “Yes” “No” or “Not Applicable”.

Pilot

Prior to full implementation the tool was further tested through a pilot. The purpose of the pilot was to check feasibility of techniques and question comprehension.

The survey was tested with the people attending services, with the assistance of UISCE, an organisation representing people who use drugs. The survey was piloted in a further two CHO areas, amended and finalised. The areas the survey was piloted in provided a broad range of service provision and geographical spread which tested the utility of the tool.

A template for the collation of data from the survey was developed by Dr. Colin O’Driscoll in the HSE Mid-West.

The target group was any person using HSE Addiction Services (alcohol & drug) over the age of 18 attending for pharmacotherapy, detoxification or counselling. The person had to have attended at least once to complete the survey. The working group in consultation with the chief researcher from the Health Research Board (HRB) devised a sample size based on National Drug Treatment Reporting Statistics (NDTRS) returns for 2014 for the two selected CHO areas. A cross sectional random sample was selected from both areas. In one CHO area there were eighteen sites and in the second CHO there were thirty three sites delivering addiction treatment. Some sites have relatively few treatments e.g. three compared to 532 treatments in another site. In consultation with the area managers designated sites were selected for the pilot phase. Four sites selected in one CHO area and eight in the second. It was agreed to target a minimum of 10% of total attendees on a particular month and to pilot over four consecutive days in June 2016.

Ten questionnaires per location were disseminated. For the pilot phase, an interviewer administered the questions or assisted the Service User to complete the questionnaire. A further ten questionnaires were left in a prominent location at each site in order to identify the uptake without verbal prompting. Completed questionnaires were posted in to a sealed box in reception.

Following the pilot, the interviewers and key stakeholders met to review the findings of the pilot under the following broad themes:

1) Was it easy to get the Service User to engage with the process?
2) Was there any obvious difficulty with question interpretation?
3) Was the promotional material adequate?
4) Did you as staff feel comfortable introducing the questionnaire?
5) What concerns would you have about Service Users completing the survey?
6) Did you notice any changes in your own behaviour over the two days whilst the pilot was on?
7) Were the questions easily understood?
8) What other questions should be included?
9) Other observations

Amendments to the questionnaire were made following the pilot and prior to full implementation.

Implementation

Following the finalisation of the survey instrument, an implementation plan (Appendix 7) was developed for this survey (Appendix 8) which identified that the survey could be distributed and completed in two ways. Firstly, self-completion of the survey, whereby copies were made available in the waiting areas of services for people using the service to complete was approved. The confidentiality of the survey was maintained by making a secure box available for completed questionnaire.

Secondly, staff were selected to facilitate completion of the survey with people using the services. Managers were asked to consider requesting staff from different locations to attend their service in order to allow respondents to be more at ease completing the survey honestly and without fear of compromising their care.

A poster with information about the survey (Appendix 9) was placed in prominent areas around the service for up to a month prior to the survey taking place.

The purpose of the survey was to:

- Provide a baseline of the experience of the people who use HSE Addiction Services.
- Inform national service objectives.
- Assist CHOs to:
    - Inform service planning and identify priorities annually from the perspective of people who use the services.
    - Identify quality improvements.
- Enhance involvement from people who use our services.
- Enhance staff performance.

Following the survey, it was suggested that feedback on the results of the survey be given to the people using the services, perhaps through a poster in the service. It was also suggested that managers provide feedback to CHO area operational and governance groups on themes such as potential risks and staff training needs.

The total number of respondents was 1746 across eight of the nine HSE Community Health Organisation areas (table 2). CHO 7, which includes Kildare, West Wicklow, Dublin West, Dublin South City, and Dublin South West, did not use the Service User Experience Survey. CHO 9, which had the largest number of completed surveys (1201), was reported on through 3 separate reports: CHO 9A, CHO 9B and CHO 9C. Figure 1 shows the number of respondents per CHO. Note that CHO 9 makes up 69% (n=1201) of the total number of respondents.

Table 2: Community Health Organisations (CHOs)

CHO	**Covering areas**	**Respondents**
CHO 1	Donegal LHO, Sligo/Leitrim/West Cavan LHO, Cavan/Monaghan LHO	59
CHO 2	Galway, Roscommon and Mayo LHOs	65
CHO 3	Clare LHO, Limerick LHO, North Tipperary/East Limerick LHO	114
CHO 4	Kerry LHO, North Cork LHO, North Lee LHO, South Lee LHO, West Cork LHO	117
CHO 5	South Tipperary LHO, Carlow/Kilkenny LHO, Waterford LHO, Wexford LHO	132
CHO 6	Wicklow LHO, Dun Laoghaire LHO, Dublin South East LHO	39
CHO 7	Kildare/West Wicklow LHO, Dublin West LHO, Dublin South City LHO, Dublin South West LHO	0
CHO 8	Laois Offaly LHO, Longford/Westmeath LHO, Louth LHO, Meath LHO	19
CHO 9	Dublin North LHO, Dublin North Central LHO, Dublin North West LHO HSE treatment centres, satellite clinics, needle exchange	569
	HSE projects	107
	L/RDATF projects	525
	TOTAL	**1746**

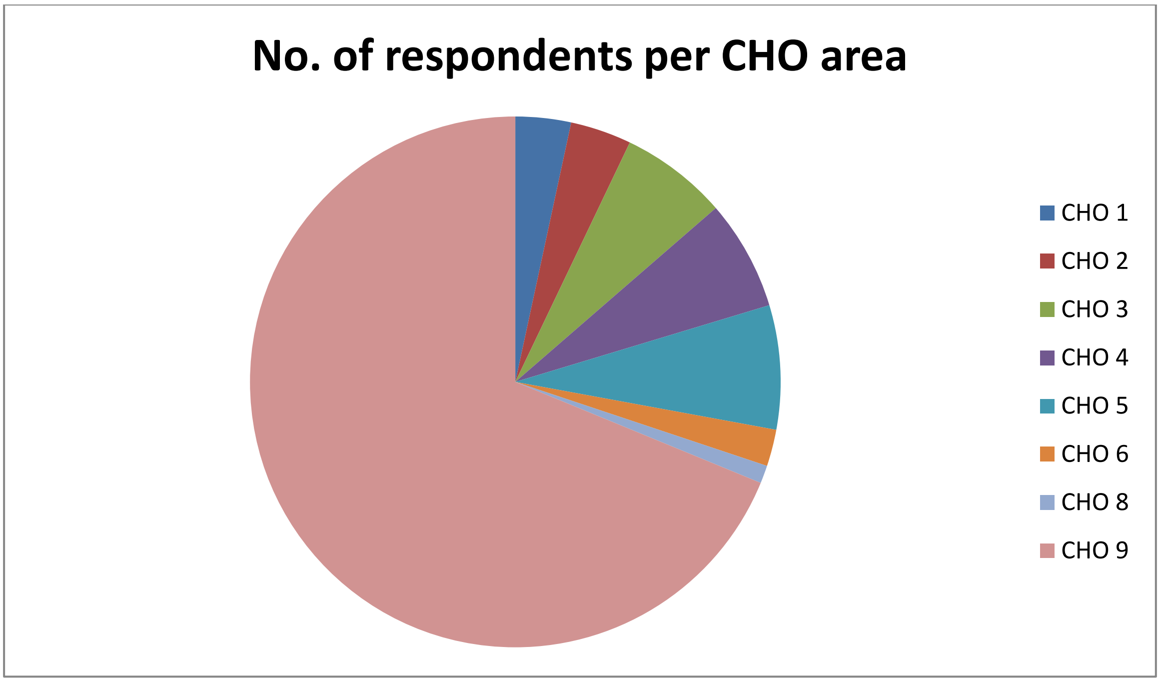


Figure 1: Number of respondents per CHO .

Limitations

The design of the survey had some limitations

A) Questions

- *Was this treatment service your first choice?* The question was limited to a 'yes/no/other' answer. It would be helpful for service planning if a narrative accompanied this question to ascertain what the preferred option would have been.

- *If you have made a complaint, were you satisfied with the way it was handled?* The question was not preceded by a question on if the respondent had ever made a complaint, therefore the result was not quantifiable i.e.: had they made a complaint and were not satisfied, or had they never made a complaint and therefore the question was not relevant to them?

B) Consistency

- The implementation of the survey posed some difficulty in some CHO areas where it was reported that there was a lack of consistency in the way the survey was carried out in different areas within the CHO, including the levels of privacy afforded to those participating in the facilitated surveys. It was also noted that some HSE staff declined to take part in the survey stating it may compromise the therapeutic relationship between staff and people using the service. There was a low uptake reported in other areas, compromising the validity of the results as representative of the population of people using the services in a CHO area. However, there is a relatively low number attending services in other CHO areas compared to CHO 9.

Quantitative results

Access to services

This question is based on standard 1.2 *Service users have equitable access to healthcare services based on their assessed needs.* Services meeting this standard will have designed the service based on information about the people using the service, including age, gender, geographical location, referral pathway and access to other services.

The people using the services were asked three questions to determine how accessible the service is: where to get help; location of services; and, if the treatment was their first choice.

Figure 2 shows that between 64% (CHO 1) and 89% (CHO 8) said that when they were ready, they knew where to find help. This could indicate that the referral pathways are established and working well among Tier 1 and 2 services in the areas surveyed.

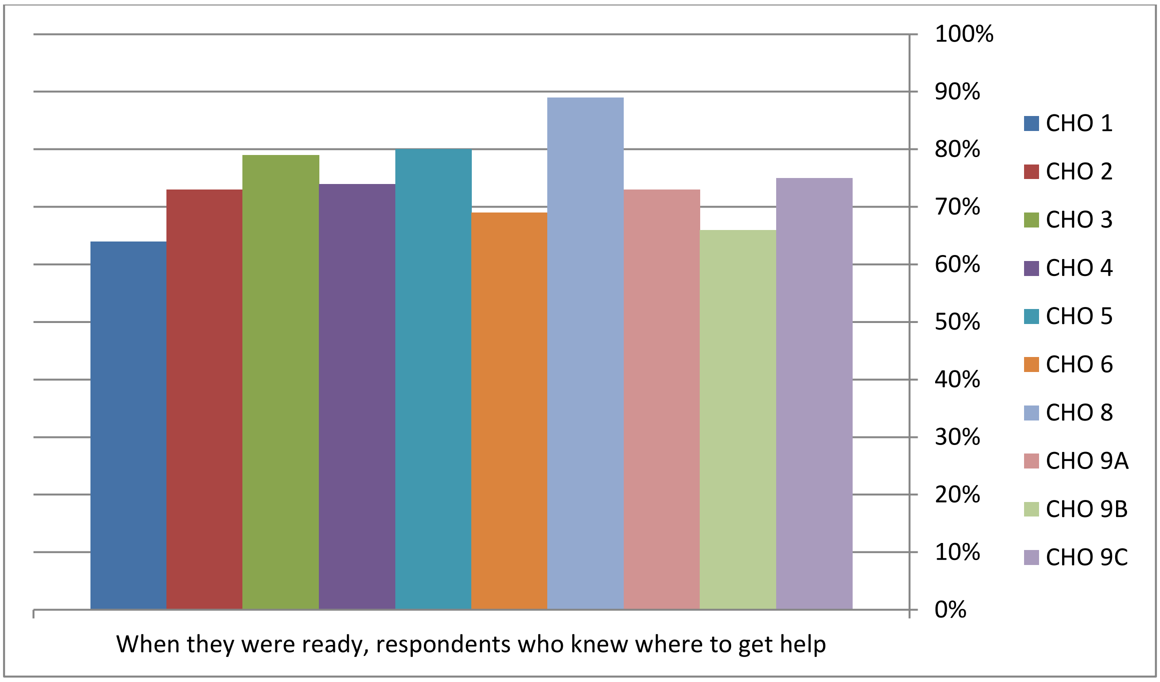


Figure 2: Accessibility.

The majority of respondents said it was clear how to get to the treatment centre and that the treatment service was their first choice. However, a significant number of people said the treatment service offered was not their first choice, a quarter of those surveyed in some areas (CHO 1, CHO 2, CHO 4, CHO 6, CHO 8). Further analysis of this finding was not possible with the information collected in this study.

Making informed decisions about care

These questions are based on standard 1.4 *Service users are enabled to participate in making informed decisions about their care.* Services that are meeting this standard would typically provide information to the people using their service on the treatment, the options available to them, the support services available to them and the cost of the service.

The people accessing the services were asked a series of questions to determine if they had sufficient information to inform their decisions on their care. The results were very varied. The majority of respondents across all areas felt they had been given enough information on peer support groups. There were mid-range results on the information people reported having on the length of treatment episodes and what would happen if they missed an appointment. Worryingly, in one area a respondent reported they had been told they would be attending the service for life.

A significant finding from both the question about cost and the qualitative responses was that approximately half the respondents did not have any information on the cost of the service (figure 3). As noted in some reports, while those who work within the alcohol and drug sector may know that these services are free, it was clear from these findings that some of the respondents did not know this. In one area (CHO5) it was noted from the qualitative results that some respondents may have included, in responding to this question, the cost of daily travel from rural areas to towns where the dispensing pharmacies are, which is a cost they may not have factored in prior to treatment. The results on cost are worthy of action as misinformation, or indeed no information, on cost could be an unnecessarily barrier to accessing services.

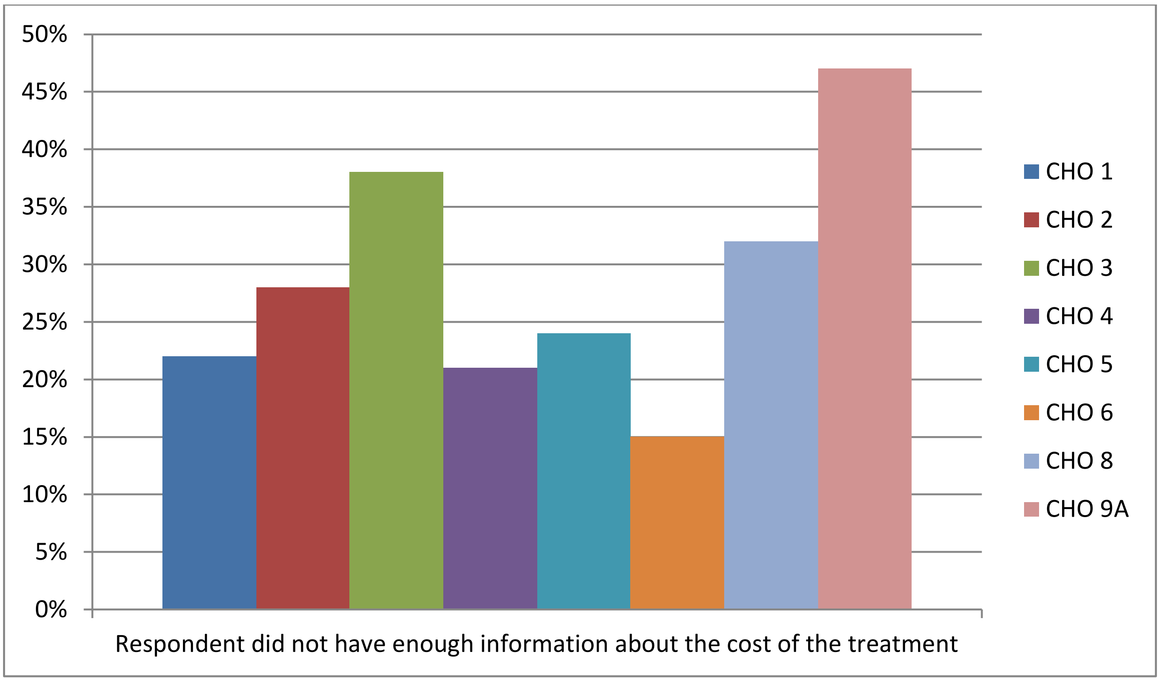


Figure 3. Respondents who did not have enough information about the cost of treatment.

Respect for patient centred values, needs and preferences

These questions are based on standard 1.1 *The planning, design and delivery of services are informed by Service Users' identified needs and preferences* and standards 1.4 *Service users are enabled to participate in making informed decisions about their care*. Services meeting these standards will typically involve the person in their care plan and will provide services at a time and place which takes into account the needs and preferences of the Service User.

All services scored highly regarding patient centred values, needs and preferences. A high number of respondents reported that staff took the time to get to know them and their expectations, that they were able to make an appointment for a time that suited them and that the service was flexible if something didn't suit the person using the service.

When asked if they felt involved in their care plan, an average of 89% of respondents said they felt involved in their care plan. This is with the exception of the services in CHO 9A, which had a lower response of 63%. The results are presented in figure 4.

The services surveyed area CHO 9A included treatment centres, satellite clinics and needle exchange services. One clinic in this area reported that only 14% of people felt involved in their care plan, with the remaining services averaging about half reported they felt involved. These findings represented just under a third of the total responses for the CHO 9 area in total and are worthy of further investigation and action in the specific treatment centres and clinics.

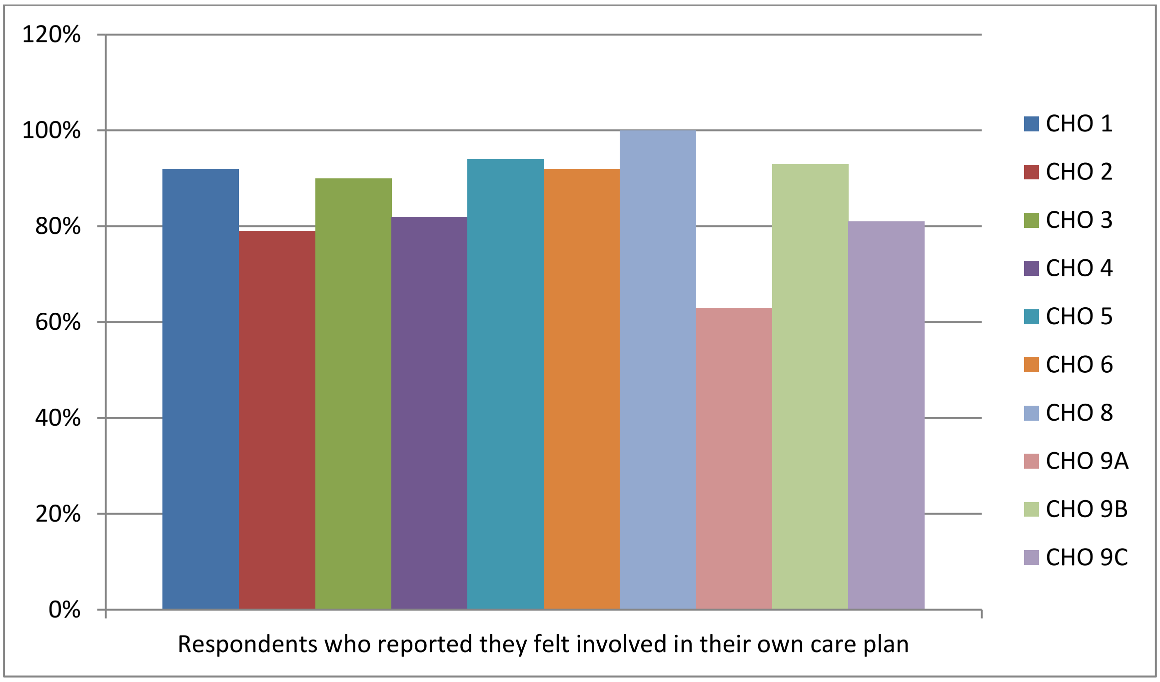


Figure 4: Involvement in care plan

Maintaining and improving own health and wellbeing

These questions are based on standard 4.1 *The health and wellbeing of Service Users are promoted, protected and improved*. For services meeting this standard, they will use opportunities to identify and promote better health and wellbeing among the people using their services.

People were asked if the service encouraged them to make positive changes to improve their health and wellbeing in the following areas: alcohol use, drugs use, smoking, eating, physical exercise, sexual health and mental health.

In general, the results showed that the majority of respondents reported being encouraged to make positive changes to alcohol use or drug use and mental health.

The other domains were mid-range, with the exception of sexual health, which had lower results. Figure 5 presents the results for three domains: alcohol use, mental health and sexual health.

Where results were lower, some areas (CHO3, 4, 9A, 9B) noted that people were not necessarily presenting for treatment in all the domains and therefore might not be encouraged to make changes in those domains. However, according to CHO4

> *It would be beneficial for Service Users to receive consistent messages around health management in all aspects of their lives as per the 'Healthy Ireland Framework'. When the standard is met it should mean that Service Users "receive advice and information to help identify opportunities for you that may lead to a healthier lifestyle" (National Standards for Safer Better Healthcare – Health Information and Quality Authority 2012 p.10).*

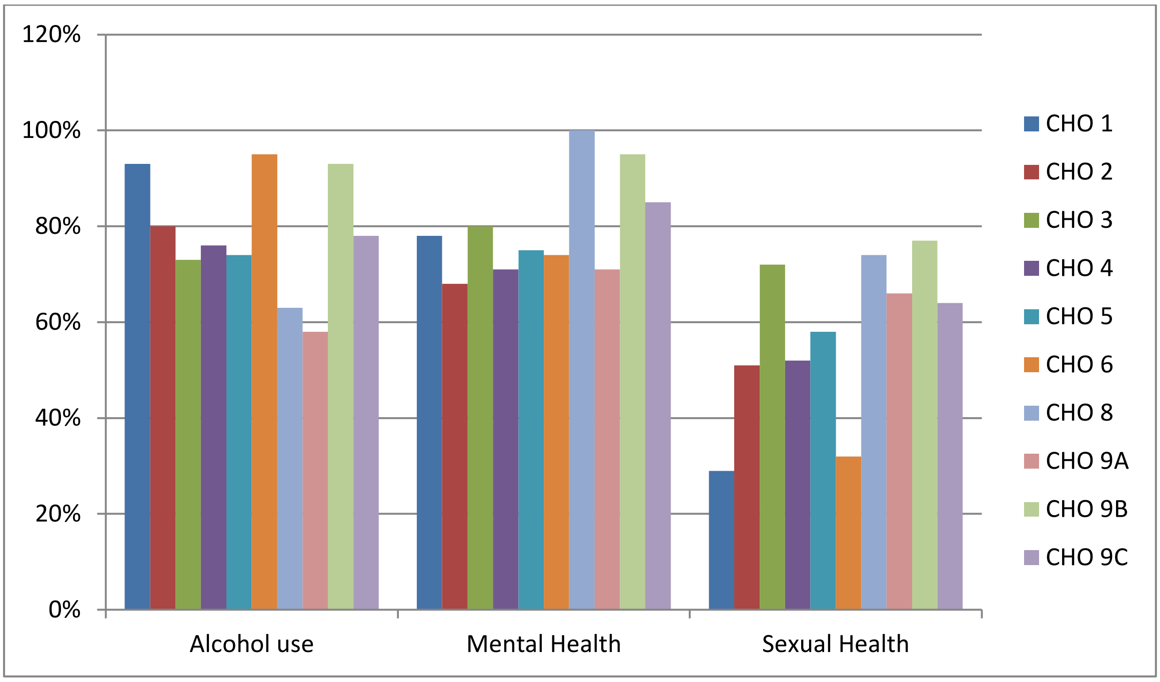


Figure 5: Respondents were encouraged to make positive changes to their alcohol use, mental health and sexual health.

Informed consent

These questions are based on standard 1.5 *Service users' informed consent to care and treatment is obtained in accordance with legislation and best available evidence*. Services meeting this standard will have arrangements in the service to facilitate informed consent, including for those who are not in a position to give informed consent themselves.

Informed consent was measured through three questions: if people were asked to sign a consent form; if it was explained to them when and how the service communicates with the other agencies that support you; and if it was explained to them, when the service cannot keep your information confidential.

Overall, on average 86% of people reported having signed a consent form. This is with the exception of CHO6, where just over half the respondents indicated they were asked to sign a consent form (56%).

Figure 6 shows specific communications on consent

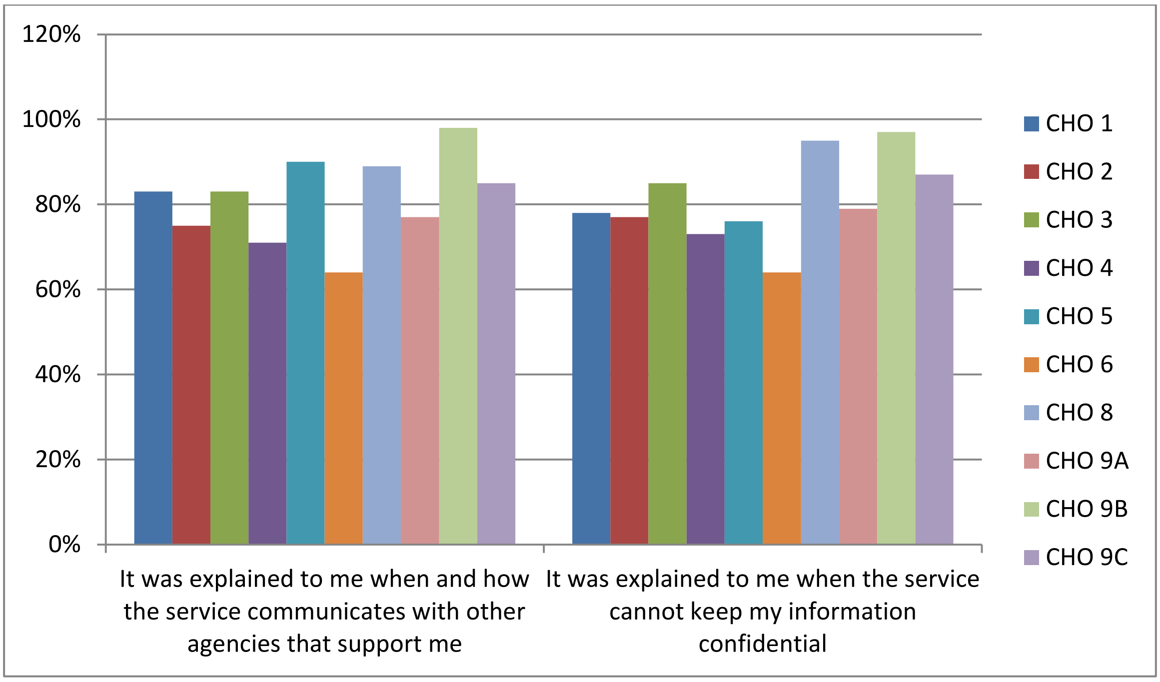


Figure 6: Consent explained.

Kindness, consideration and respect

These questions are based on standard 1.6 *Service users' dignity, privacy and autonomy are respected and promoted*. Services meeting this standard will deliver services and communicate in a manner that respects the dignity of the people using the services.

Kindness, consideration and respect were measured through five questions: do you think staff treat you as an equal; do you always feel safe in the service; do you feel that you are listened to; do you know how to make a complaint; and if you made a complaint were you satisfied with the way it was handled.

Across all areas, the vast majority of respondents indicated that they feel they are treated like an equal, they feel safe, they feel they are listened to and are communicated with in an appropriate fashion.

The results relating to complaints indicated that not all people were aware of how to make a complaint, a quarter of those surveyed in some areas (CHO 1, CHO 4). Figure 7 illustrates this.

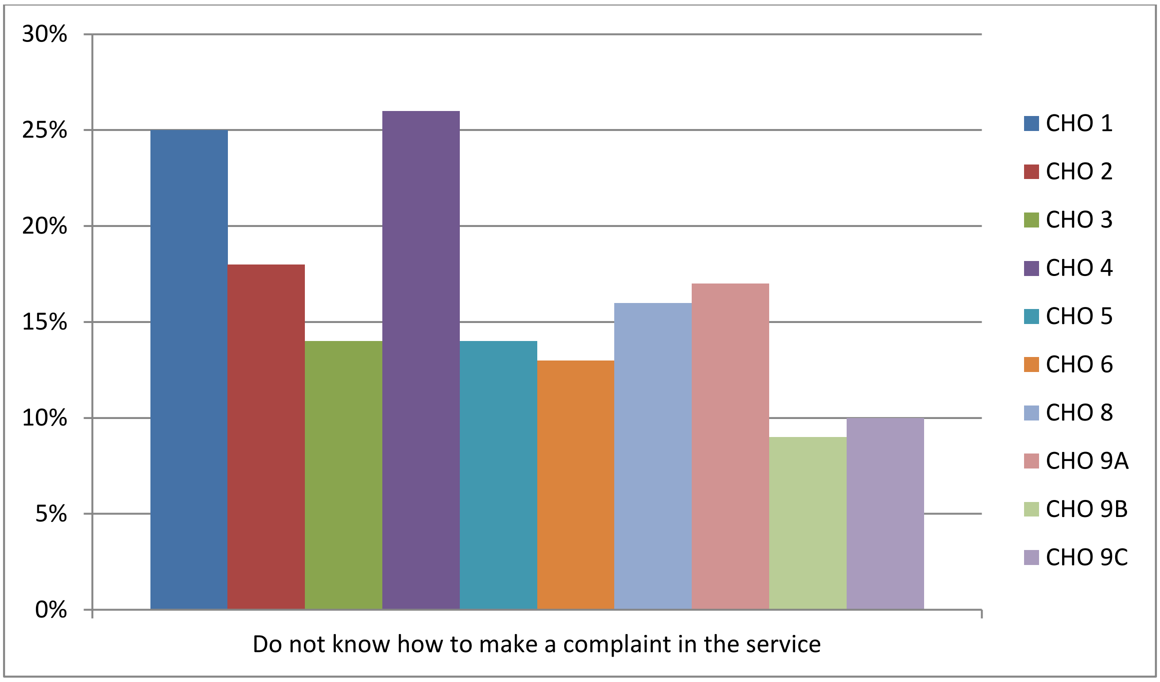


Figure 7: Respondents who did not know how to make a complaint in the service

While there was a low percentage of people who indicated they were satisfied with how their complaint was handled, there were very high results for respondents choosing to respond as ‘other’. This may be an indication that this question did not apply to the majority of people surveyed. The question could be analysed further if it was known how many people surveyed had made a complaint. However, this was not included in the survey, so such an analysis is not possible.

Dignity, privacy and autonomy

These questions are based on standard 1.6 *Service users’ dignity, privacy and autonomy are respected and promoted*. Services meeting this standard will deliver services and communicate in a manner that respects the dignity of the people using the services. This includes managing the physical environment in which services are delivered.

The dignity, privacy and autonomy felt by the people who use the service was measured by asking: Do you feel the service respects you as an individual and supports you to maintain your dignity; and are you given privacy if you want it.

The results for this section were overwhelmingly positive with a high percentage of people, between 81% and 98% of respondents, felt they were respected as an individual, supported to maintain their dignity and were given privacy if they wanted it.

Diversity and recommending the service

These questions are based on standard 1.3 *Service users experience healthcare which respects their diversity and protects their rights.* Service meeting this standard provides a service that allows the people using the service to exercise their civil, political and religious rights as far as is reasonably practicable within the healthcare setting, and does not discriminate.

The people surveyed were asked if they felt they were welcomed in the service in relation to their gender, marital status, family status, age, race, religion, disability, sexual orientation or membership of the Traveller community. Again there were very high scores for this section with the vast majority of respondents stating they did feel welcomed in the service.

The survey also asked if the person using the service would recommend the service to a friend or family member. The results are presented in figure 8.

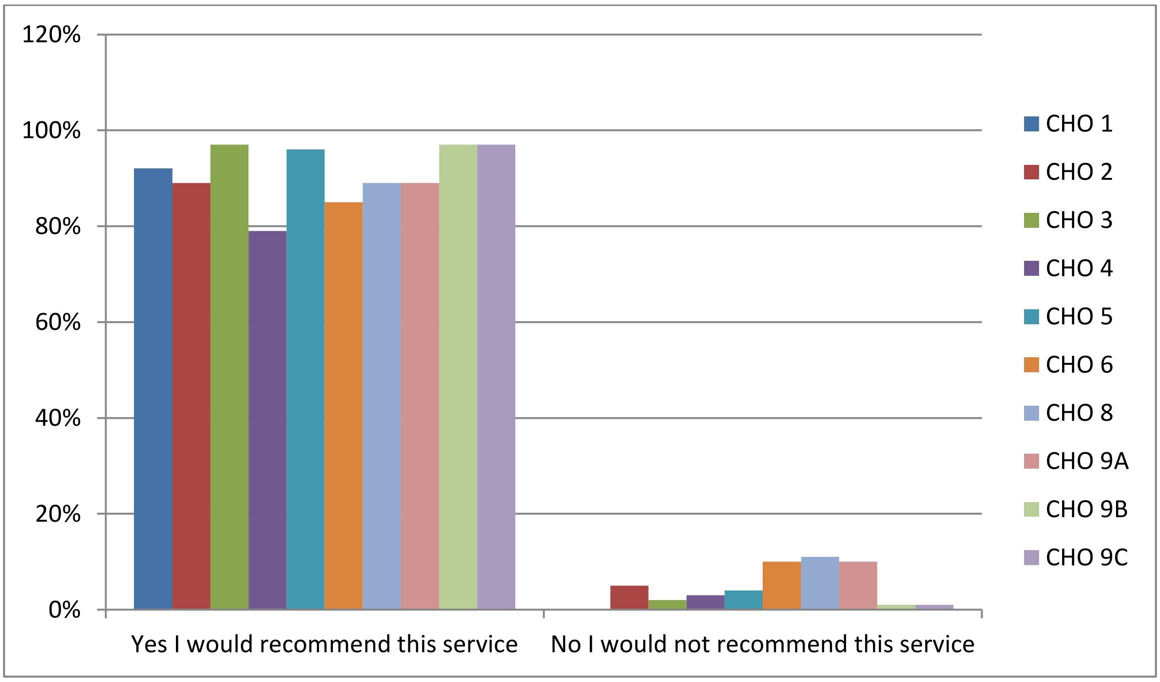


Figure 8: Respondent would/would not recommend the service to a friend or family member

Qualitative results

Summary of strengths

The comments on the strengths of the service pointed most strongly to the staff. Respondents reported the staff as supportive, non-judgemental and approachable. Counselling staff were reported as building connections with the people using the service. There were positive reports of how the people using the service felt treated by the staff, including the security staff in some services.

Overall, on average 86% of people reported having signed a consent form.

Respondents reported feeling safe in terms of their health, privacy and confidentiality in the service. Mental health concerns were addressed for some respondents.

The services were reported as being flexible and understanding, particularly with regard to missed appointments through court appearances or relapse.

There were positive reports overall of the service being accessible to anyone who needed support, which is provided in a non-judgemental way.

Summary of weaknesses

A small number of respondents reported feeling the staff were condescending to them and dismissive of them. Some also felt the Doctor in the clinic did not listen to them and that they didn't have enough time with the Doctor or with the nursing staff.

Respondents reported that more treatment options could be available to them, including interventions specific to mental health and sexual health. Some reported they would like to be prescribed Suboxone. The lack of options for moving on from the service was also named.

Access to the service was cited as a weakness. Long waiting lists were one named cause. The other was the geographical spread of services. There were reports of long travel times and a reliance on public bus services which can be problematic when there is strike action. The cost of transport was also cited as a barrier to access.

Awareness of the service was named as a weakness in some areas with some describing how they did not know there was a service as there is no advertisement of the service in the area. People using the service were able to give the information to others who may wish to access the service.

As small number of respondents reported other people dealing drugs in the service, which is a risk to their recovery. A small number of respondents also reported the lack of childcare facilities for women, which was reported as a barrier to accessing day services.

Summary of other comments

Other comments were generally positive and most related to the support given to the person by all staff working in the service, and to the lack availability of services in their area necessitating travel to clinics.

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Appendices

Appendix 1: NHS Patient experience framework

NHS PATIENT EXPERIENCE FRAMEWORK (2011)

1) **Respect of patient-centred values, preferences, and expressed needs** including cultural issues, the dignity, privacy and independence of patients and service users, an awareness of quality-of-life issues and shared decision making.
2) **Coordination and integration of care** across health and social care systems
3) **Information, Communication, and Education** on clinical status, progress, prognosis and processes of care in order to facilitate autonomy, self-care and health promotion.
4) **Physical Comfort** including pain management, help with activities of daily living and clean and comfortable surroundings.
5) **Emotional Support** and alleviation of fear and anxiety about such issues as clinical status, prognosis, and the impact of illness on patients, their families and their finances.
6) **Welcoming the involvement of families & friends**, on whom patients and service users rely, in decision – making and demonstrating awareness and accommodation of their needs as care-givers.
7) **Transition and Continuity** as regards information that will help patients care for themselves away from a clinical setting, and coordination, planning, and support to ease transitions.
8) **Access to care** with attention for example, to time spent waiting for admission or time between admission and placement in a room in an in-patient setting, and waiting time for an appointment or visit in the out-patient, primary care or social care setting.

Appendix 2: NHS outcomes framework 2011/12, Domain 4

NHS Outcomes Framework Indicators

Background.

The framework was developed in December 2010, following public consultation, and is updated on an annual basis to ensure that the most appropriate measures are included. Indicators in the NHS Outcomes Framework are grouped around 5 domains, which set out the high level national outcomes that the NHS should be aiming to improve. For each domain, there are a small number of overarching indicators followed by a number of improvement areas. They focus on improving health and reducing inequalities.

Domain 1 – Preventing people from dying prematurely.

This domain captures how successful the NHS is in reducing the number of avoidable deaths.

Domain 2 – Enhancing quality of life for people with long term conditions.

This domain captures how successfully the NHS is supporting people with long term conditions to live as normal a life as possible.

Domain 3 – Helping people to recover from episodes of ill health or following inquiry.

This domain captures how people recover from ill health or injury and wherever possible how it can be prevented.

Domain 4 - Ensuring that people have a positive experience of care .

This domain looks at the importance of providing a positive experience of care for patient, service users and carers.

Domain 5 - Treating and caring for people in a safe environment and protecting them from avoidable harm.

This domain explores patient safety and its importance in terms of quality of care to deliver better health outcomes.

Appendix 3: Literature Review

Author: Cora McAleer, Clinical Nurse Manager 3, Mental Health & Addiction Services Donegal.

There has been a rapid expansion in the use of the term Service User experience in healthcare in clinical practice and in research. According to Wolf, Niederhausser & Marshburn (2014), this has been driven by a shift in public policy that has put the experience of Service Users front and centre. There is an increasing acceptance that Service User experience is now a top priority for healthcare leaders. Ireland is no different, and Service User experience is steadily moving up the agenda of our own healthcare leaders. Yet in practice and research the concept of Service User experience has varied uses and is often discussed with little more explanation than the term itself. It is fair to say that Service User experience is very individual but at the same time the elements that make for a good Service User experience across the health services are generic.

This literature review was aimed at exploring the concept of Service User experience in order to translate the literature into designing a Service User experience tool that could be used across the HSE Addiction Services in Ireland. Addiction Services in Ireland vary across the country in terms of an interface between Mental Health and Primary Care. Therefore the tool designed had to be transferable, as the literature indicates measuring experience is firstly about understanding what makes a good experience for Service Users regardless of where they are treated.

Search Strategy

Literature was reviewed from 1995 to 2015. The search was conducted between October 2015 – January 2016 in the English language, using a search of HSE Land, RCSI & HSE online library resources inclusive of PubMed Medline databases, Ovid, Cumulative Index to Nursing and Allied Health Literature (CINAHL), Emerald & Psych INFO. In addition, Internet search engines, (Google, Google Scholar) were used to capture information from the grey literature. Major health organisations and research companies were utilised such as the Beryl Institute, Picker Institute, NHS Quality & Improvement website, The Kings Fund, Institute for Healthcare Improvement (IHI), Planetree and Association of Service User Experience and Beyond Philosophy resulting in an additional sixteen potential information sources. Furthermore a manual review through the reference list of some of the key articles yielded seven further resources.

Several combinations of multiple key words and search terms were used including:

- Service User experience in addiction treatment
- Service User experience in alcohol and drug services
- Standardised tools to measure Service User experience
- Satisfaction surveys on addiction treatment

Unfortunately the search terms inclusive of "addiction" or "alcohol and drug treatment" alongside Service User experience returned minimal results with only two key articles retrieved. The search was changed then to a more general search which had a different outturn these search terms then included:

- Service User experience
- Defining Service User experience
- Measuring Service User experience
- Tools to measure Service User experience

- Service User Experience + Quality of Care
- Outcomes of Service User experience surveys

Inclusion / Exclusion Criteria

Papers returned in a foreign language were rejected.

Themes from the Literature Search

The most predominant theme that emerged included 1) **policy framework** which suggests how much policy is being determined by a strong evidence base. Other themes include 2) **drivers/leaders for gathering Service User experience, 3) what is important to Service Users, 4) experience frameworks, 5) measurements.**

The Policy Framework

The National Institute for Clinical Excellence (NICE) (2012) developed a detailed quality standard framework and guidelines for Service User experience, which the NHS has adapted to produce the NHS Service User experience framework, (Appendix 1). Furthermore the NHS Outcomes Framework (2010) has put Service User experience as a central pillar, (Domain 4) (Appendix 2). Service User experience is therefore seen as a central outcome for the NHS alongside clinical effectiveness and Service User safety, de Silva (2013).

In Ireland, recent years have seen Service User experience climb up the agenda of policy makers. This is evidenced by the frequent actions set in Service Plans and in Government Strategy which has been previously outlined. In many EU countries, Service User experience reviews are mandatory. According to a review commissioned by the European Parliament (2008) this is the case for Denmark, Norway, the UK and the Netherlands. Outside Europe Service User experience reviews takes place in the US and in Canada. Furthermore a report from the Norwegian Knowledge Centre (Garratt et al, 2009) states that in addition to National programmes, the Picker Institute and the World Health Organisation (WHO) have undertaken cross national comparisons of Service User experiences and they note that the USA and the UK have by far the longest tradition of measuring Service User experience. There are a number of relative policy documents, drivers, incentives and sanctions in various countries that make improving Service User experience an imperative, such as the public reporting and pay for performance programs in the U.S. In addition the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Hospital surveys in America are shown to have made positive changes as hospitals were able to use the data gathered from the people using their hospitals to actually improve the Service User experience (Price et al, 2014). Furthermore (Fox et al, 2013) proclaim that there is growing evidence that clinicians are responsive to publicly reported information about Service User experiences of care.

Making the case for Service User experience (drivers)

Leaders are encouraged to embrace this increasing emphasis on Service User experience and view it as important as other quality indicators. According to the Institute of Medicine Report – Crossing the Quality Chasm (2001) Service User experience is increasingly recognised as one of the 3 pillars of quality in healthcare alongside clinical effectiveness and Service User safety. In the NHS the measurement of Service User experience data is now mandatory in an effort to drive quality improvement and to promote Service User choice (Black, 2009). In the UK healthcare providers are now assessed on relational aspects of care such as dignity and respect, and Service User involvement in care decisions. Furthermore this data is published in quality accounts which make a proportion of care provider income conditional on the improvement in this domain (NHS, 2009). Measurement of Service User experience is noted to be important because it provides an opportunity to improve care, enhance strategic decision making and meet Service User's expectations (Al-arbi, 2014). In the US this movement was prompted in part by the Institute of Medicine Report, Crossing the Quality Chasm (2001) and further prompted by the public reporting of measures such as the Hospital Consumer Assessment of Healthcare Providers and Systems (Centers for Medicare and Medicaid Services). In addition, the increase of Service User experience measures for accreditation purposes and pay for performance programmes has also been a factor (LaVela, 2014). No doubt there is strong policy interest in linking payment to Service User experience but there remains important questions according to Marben et al (2012) as to how a transactional incentive (particularly one at a whole organisational level as typically envisaged) can really influence improvements in relations between individual people. Healthcare leaders need to collect a body of evidence that will convince business leaders across the service of the importance of investing in Service User experience. There is emerging evidence that organisations with a strong emphasis on providing high quality Service User experience have found that it is linked to better health outcomes.

In the UK, a public enquiry into major failings in health care in the Mid Staffordshire NHS Foundation Trust (Francis, 2013) concluded that a major failing was not listening to Service Users either reactively through complaints or proactively through seeking feedback. Doyle, Lennox & Bell (2013) proclaim that if Service Users do not feel involved in decisions about them, they are much less likely to follow advice given. The mantra *no decision about me, without me* is small but full of meaning. If people do not understand what is happening, they will be less safe and less likely to gain from a clinical intervention. Doyle et al. (2013) ascertains that poor communication at discharge is a well-known factor for re-admission and further purports that the evidence is very clear a better Service User experience leads to improved clinical outcomes and reduces safety risk.

What is important to Service Users?

Many studies have examined what Service Users view as important to them. In Scotland (Reeves and Bruster, 2009) 2,213 Service Users discovered range of care aspects that were deemed important to Service Users, these findings are consistent with other research in this field such as the study by Boyd in (2007). Table 3 summarises what was found in both studies.

Table 3: Themes emerged as Important to Service Users from England & Scotland

Reeves & Buster (2009) Scotland	Boyd (2007) England
A clean ward	Doctors' knowledge of Service User history
Staff cleaning their hands	The doctors being able to answer my questions in a way I can understand.
Being treated quickly in an emergency	Having confidence and trust in the hospital staff who treat me.
Getting the best treatment for the condition	Doctors washing their hands between Service Users.

Doctors knowing enough about my condition	Nurses knowing enough about my medical history and treatment
Clear explanations about what will happen During an operation or procedure	Before my operation or procedure, I get clear explanation of what will happen
Being told the risks and benefits of any Treatment in a way I understand	Risks and benefits explained in a way I understand
Clear explanations of my condition or treatment	Nurses wash their hands between Service Users
Being treated with dignity & respect	The rooms and wards are clean
Being told the outcome of the procedure In an understandable way	The doctors and nurses are open with me about my treatment or condition

One of the most referred to reports during this literature search was the second report commissioned by the NHS carried out by Kings College London 'What matters to Patients (2011). Many of the findings from this research of voluntary organisations showed remarkable consistency across conditions and in relation to the various sectors, generic themes were:

Table 4: Extrapolated from Kings College London (2011)

- Good information provision.
- Having confidence in health professionals.
- Awareness and understanding of specific health conditions.
- The right treatment from the right staff at the right time.
- Continuity of care.
- Being treated as a person.
- Partnership with professionals.

The findings from this survey of voluntary organisations and Service User groups broadly support the argument that a generic framework of what matters to Service Users could be applied across conditions and sectors. They also support the importance of the 'relational' aspects of care. The What Matters to Service Users report also included 50 narrative based interviews relating to what is important to Service Users when receiving care in relation to one of the five selected 'tracer' conditions. Twenty themes emerged and many of these were generic across all conditions but there were also a small number of themes that were condition specific. The most common generic themes were:

Table 5: Extrapolated from Kings College London (2011)

- Feeling informed and being given options.
- Staff who listen and spend time with Service User.
- Being treated as a person, not a number.
- Service User involvement in care and being able to ask questions.
- The value of support services (for example Service User & carer support groups).
- Efficient processes.

Again the findings from the narrative interviews support the argument that a generic framework can be used across a range of conditions and that relational aspects of care are important to Service Users.

The Picker Institute (2009) promote the following eight aspects of healthcare as being most important to Service Users:

Table 6: Extrapolated from The Picker Institute

1. Fast access to reliable health service.
2. Effective treatment delivered by trusted professional.
3. Involvement in decisions and respect for preferences.
4. Clear, comprehensible information.
5. Attention to physical and environmental needs.
6. Emotional Support, empathy and respect.
7. Involvement of, and support for family and carers.
8. Continuity of care and smooth transitions.

The major reports highlighted above emphasise the commonality of care attributes that Service Users really feel are important for a good Service User experience of care.

Developing a framework on what is important to Service Users

The National Institute for Health and Clinical Excellence (NICE) (2012) has condensed the 65 recommendations contained in their Service User Experience Clinical Guidelines into 14 Quality Statements. These statements embody best practice and evidence. The Picker Service User Experience Framework, the Warwick Service User Experience framework and the American Institute of Medicine, are by far the most utilized and researched Service User experience frameworks to date. They are fundamentally based on a sound evidence base of what matters to Service Users. The National Quality Board (NQB) for England decided that the Picker Framework more closely reflects the healthcare system in the UK, hence they adapted this framework with some additions including dignity, privacy and independence of Service Users supporting decision making. In Ireland, the Service User is central to Theme 1 in the HIQA National Standards for Safer Better Healthcare (2012). It is Theme 1 of the National Standards document that is the major driver for this survey and report.

Tools to Measure Service User Experience

LaVela (2014) explains that Service User experience is a unique encompassing dimension of healthcare that is complex to measure. Wiig et al. (2013) stated that tools for measuring and using Service User experience for quality improvement goals are lacking, and where measures are available there are no systematic use of these measures. LaVela (2014) asserts that the starting point for measuring Service User's experiences would ideally include a standardized definition, an established set of standards, and a set of measurable indicators.

LaVela (2014) suggests that measuring Service User experience can be best accomplished using mixed methods both qualitative and quantitative. This allows a fuller picture and enables the service to cross validate. In recent years several healthcare organizations have attempted to measure experience using a variety of quantitative and qualitative approaches, such as ward surveys, interviews, focus groups, Service User forums, and advocacy group. Other approaches are formal complaint mechanisms and websites (Wiig et al., 2013).

There are many validated tools available, some of the most frequent tools that appear in the literature are:

- Client Satisfaction Questionnaire (CSQ). (Larsen et al, 1979)
- Service User Experience Questionnaire (PEQ). (Steine et al, 2001)
- Picker Service User Experience Questionnaire (PPE-Q). (Picker Institute, 2002)
- The Treatment Perception Questionnaire (TPQ). (Marsden et al, 2000)

The (CSQ) arguably the most widely used existing client satisfaction measures developed by Larsen et al (1979) has been developed in many forms and used extensively in health service research. However the CSQ has not been without its critics according to Marsden et al (2000). The PEQ is an 18 item questionnaire and has been validated for out-patient Service User consultations and measures Service User experience on the following domains; communication, emotions, and short term outcomes. Upon studying the PEQ it was deemed limited in terms of other domains of experience that we would be keen to measure after researching the wider Service User experience literature. The PPE is a 15 item questionnaire that has been validated for in-patient Service User settings and covers a wider range of experience metrics and has been employed extensively by the NHS. In relation to addiction treatment there were few validated tools specifically for addiction. However the TPQ is one of the most validated questionnaires in the literature and has been designed to measure client satisfaction with treatment for substance use problems. (Marsden et al, 1998) noted that there was a dearth of literature on client treatment satisfaction issues in the substance use treatment arena and furthermore there was no specific research instrument to assess treatment satisfaction amongst the substance misuse treatment population. Capitalising on this deficit Marsden et al (2000) devised the Treatment Perceptions Questionnaire (TPQ). The aim of the TPQ was that a set of items which would cover specific areas of concerns identified by clients in addiction treatment and that could also be used across treatment modalities and settings. The TPQ does cover relational aspects of care but does not cover all the domains of Service User experience which is the aim of this particular survey. None the less we acknowledge the very useful contribution the TPQ has made to measuring Service User satisfaction within addiction treatment.

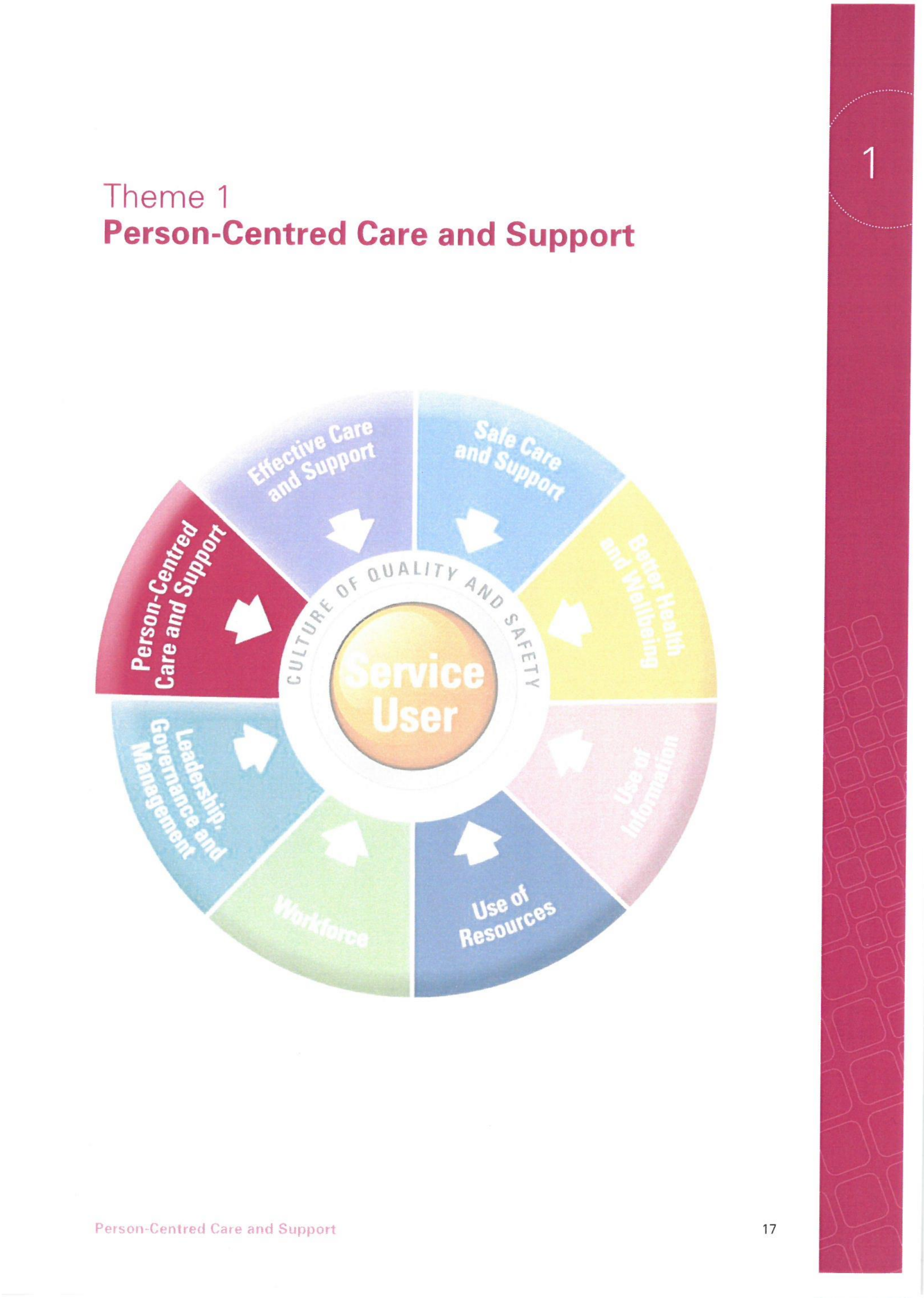
Finally another method worth commenting on is the NHS Family and Friend Test (FFT) which was launched in 2013. The FFT is a simple question that Service Users across the UK are asked about the care they have received. Service Users are asked,

“How likely are you to recommend our services to friends & family if they needed similar care or treatment?”

Service Users can choose from a number of responses ranging from “extremely likely” to “extremely unlikely”. Data from the NHS website tells us that more than 10 million pieces of Service User feedback have been received since the FFT has been introduced. Furthermore teams around the Country have made countless improvements by reading Service User comments and acting on them thus providing valuable insight in to Service User experience in the UK.

There is a clear dearth of research on Service User experience in addiction treatment provision. However the literature search has led us to form the idea that the components that make a good Service User experience which in turn has a positive impact on care are mainly relational aspects of care which should be generic and not setting specific. The realisation was a welcome one as the provision of Addiction Services is so diverse that it would be impossible to design a standardised tool to gather experience based on transactional care. This in no way renders measuring transactional care as unimportant but it is beyond the scope of this report.

Appendix 4: National Standards for Safer Better Healthcare Theme 1



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Theme 1

Person-Centred Care and Support

Person-Centred Care and Support 17

Theme 1
Person-Centred Care and Support

Person-centred care and support places service users at the centre of all that the service does. It does this by advocating for the needs of service users, protecting their rights, respecting their values, preferences and diversity and actively involving them in the provision of care. Person-centred care and support promotes kindness, consideration and respect for service users' dignity, privacy and autonomy.

By considering service users' needs and preferences in the planning, design and delivery of care and support services, better service-user satisfaction can be achieved. This, in turn, can lead to improved outcomes for service users including better health and wellbeing. Person-centred care supports equitable access for all service users so that they have access to the right care and support at the right time, based on their assessed needs. This is best achieved through an organisation-wide culture that is focused on what is most important from the service users' perspective.

Being person centred means service providers communicate in a manner that supports the development of a relationship based on trust. Good communication and the provision of adequate information ensures that service users make informed decisions about their care, including informed decision making to give or refuse consent to treatment.

Service-user participation in their own care is more likely when they are comfortable with, and confident in, those providing care and when they understand the care choices being offered to them.

Good service-user experiences are an important outcome for all healthcare services. Having a robust complaints process provides service users with the opportunity to express their views when their experiences have not been optimal, and allows service providers to identify areas for service improvement. Good communication is central to successful complaints handling and will assist in minimising the likelihood of complaints occurring in the first place.

Service users experience care and support that recognises the potential impact that requiring care can have on individuals and their families. As much as possible, people are supported to look after their own health and wellbeing and when service users do seek care, treatment or support they experience a person-centred service that responds in a manner that places the service users at the centre of all it does.

What this means for you as a service user when this standard is met:

- service users are involved in the planning and design of healthcare services in their local area
- the preferences and views of service users are taken into account by service providers when they are developing and delivering services
- feedback from service users about their experience of the service is regularly sought and used to improve the quality and safety of the service provided
- service providers, while mindful of all service users' needs, will take account of your individual circumstances when planning and delivering your care
- if you move between services all relevant information will be shared, with your permission, to ensure you receive the best care.

What this means for you as a service user when this standard is met:

- your healthcare professional will determine your healthcare needs in partnership with you
- the healthcare you receive is based on your assessed needs and is not decided by factors such as your age, where you live or whether you are male or female
- referral processes are designed so that you get the care you need when you need it.
- service users receive information about healthcare services in a way that is understandable to them
- it is clear to service users how they can access care and treatment
- it is clear to service users, how the service makes decisions about who they provide services to

What this means for you as a service user when this standard is met:

- your rights, for example your right to privacy, are respected and protected when you are receiving healthcare
- your access to healthcare is not affected by your age, gender, sexual orientation, disability, marital status, family status, race, religious belief, or membership of the Traveller Community.

What this means for you as a service user when this standard is met:

- you receive information that will help you to make decisions about your own care
- you are involved in making decisions about your own care and treatment as much as possible
- the information you receive is made available to you in a way and language you can understand
- you will be helped to access patient support services if you so wish
- if there are any direct costs to you for your care, you can expect to be told what these costs are before you are treated.

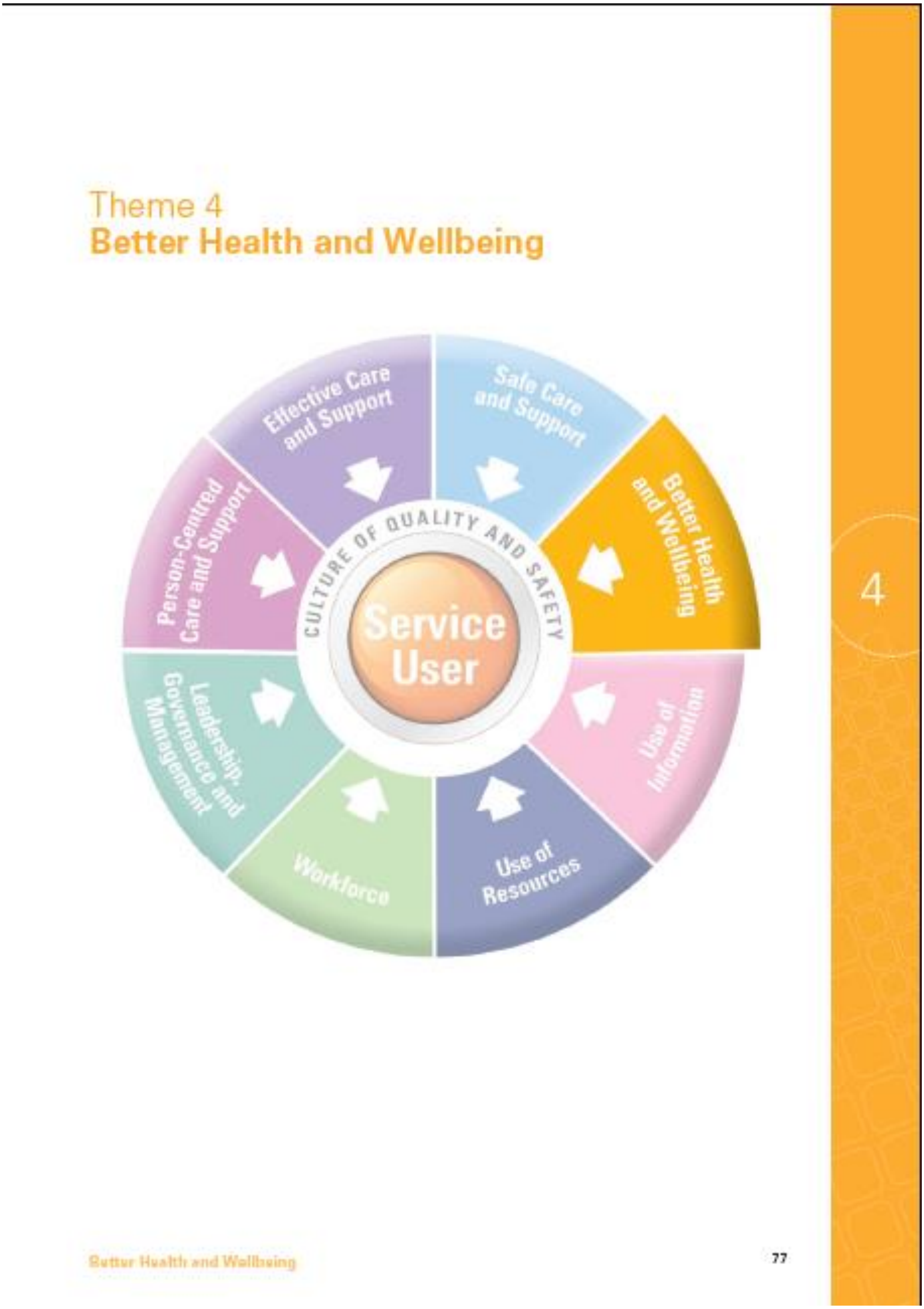
What this means for you as a service user when this standard is met:

- you will only receive care that you have given your permission for. If you are not able to give your permission, the service will have procedures in place to protect your best interests and, where possible, to find out from those closest to you what your wishes are
- you receive information about the risks and benefits of your care and treatment as well as other options that may be available to you to help you decide if you would like to go ahead with the care and treatment
- if you wish, you can bring somebody you know with you to help and support you to make decisions about your care and treatment
- you will be given time to think about any decisions that you may need to make about your care and treatment (except in an emergency where this may not always be possible)
- your decision to refuse or withdraw your permission to receive care and treatment is respected and will not influence any care and treatment which you may require in the future.

What this means for you as a service user when this standard is met:

- your personal information is protected and is only discussed, with your consent, with those involved with your treatment
- the care you receive respects your dignity and independence
- the people working in the healthcare service will listen to you
- the people working in the healthcare service will help you when you need it but will support you in maintaining your independence
- the care you receive respects your privacy in relation to your personal space, personal care and making sure information about you is kept safe and private.

Appendix 5: National Standards for Safer Better Healthcare Theme 4



Theme 4

Better Health and Wellbeing

Better Health and Wellbeing

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Theme 4
Better Health and Wellbeing

Services providing care and support have a unique opportunity to promote and protect the health and wellbeing of the population served. A high quality, safe and reliable service constantly looks for ways and opportunities to do this.

The improvement of the health and wellbeing of service users is not the sole responsibility of service users or service providers. Rather, they work together to achieve this outcome. This enables a culture that promotes better health and wellbeing, enhances the care and support environment and improves the experience for service users.

A health service that aims to optimise and promote better health and wellbeing for its service users can support this through:

- providing services that are informed by service users' needs and preferences
- working towards improving the quality and safety of care
- protecting health and preventing illness
- using health information and best available evidence to plan initiatives and interventions that improve healthcare outcomes
- using resources efficiently to achieve best possible quality and safety outcomes for service users for the money and resources used
- working in partnership with service users and other service providers to coordinate and integrate care
- supporting service users in improving their own health and wellbeing
- identifying health needs and inequalities in their service-user population.

Standard 4.1

The health and wellbeing of service users are promoted, protected and improved.

Features of a service meeting this standard are likely to include:

4.1.1 Identification and use of opportunities to promote better health and wellbeing while delivering care, in partnership with service users at individual and population levels.

4.1.2 Development and support of an environment and culture that promotes better health and wellbeing for service users and the workforce.

4.1.3 Development and delivery of programmes or initiatives to protect health and promote better health and wellbeing in line with the service's objectives and in partnership with service users. These are proportionate to the context, nature and scale of services provided and take account of national policies, stakeholders' views, best available evidence, the needs of the population served and the resources available.

4.1.4 Identification of the health priorities and health inequalities among service users and development of initiatives to minimise these inequalities in health outcomes.

4.1.5 Collaboration and working in partnership with other service providers, national and voluntary agencies and non-healthcare organisations (where appropriate) to promote the health and wellbeing of service users.

What this means for you as a service user when this standard is met:

- advice, information and support is available to help you make choices for a healthier lifestyle and to improve your health and wellbeing
- opportunities are available for you to participate in programmes or initiatives to improve your health and wellbeing
- services use information about their service-user population to design appropriate health promotion initiatives
- all your health services work with each other and with national and voluntary agencies to promote better health and wellbeing for you.

Appendix 6: QAS-99

Q1

Question Appraisal System (QAS-99)

Coding Form

Instructions: Use form for each question to be reviewed.

1) **Write in Question.**

Q 1 Access to Services
Did you know where to go to get help with your drug/alcohol problem when you needed it? Was this service easy to access?

2) **Circle or highlight YES or NO for each problem type (1a.....8)**
3) **Whenever a YES is highlighted, write detailed notes on this on this form that describes the problem**

Step 1. Reading determine if it is difficult for the interviewers to read the question uniformly to all respondents		
1a) WHAT TO READ: Interviewers may have difficulty determining what parts of the question should be read.	**YES**	**NO**
1b) MISSING INFORMATION: Information the interviewer needs to administer the question *not* contained in the question.	**YES**	**NO**
1c) HOW TO READ: Question is *not* fully scripted & therefore difficult to read.	**YES**	**NO**
STEP 2. INSTRUCTIONS: Look for problems with any introductions, instructions, or explanations from the *respondents'* point of view		
2a) CONFLICTING OR INNACURATE INSTRUCTIONS, introduction or explanations	**YES**	**NO**
2b) COMPLICATED INSTRUCTIONS, introductions or explanations	**YES**	**NO**
STEP 3- CLARITY: Identify problems related to communicating the intent or meaning of the question to the *respondent*		
3a) WORDING: Question is lengthy, awkward, ungrammatical or contains complicated syntax.	**YES**	**NO**
3b) TECHNICAL TERMS: are undefined, unclear, or complex	**YES**	**NO**
3c) VAGUE: There are multiple ways to interpret the question or to decide what is to be included or excluded. The word "access" could mean 2 things, ie get into or get to physically.	**YES**	**NO**
3d) REFERENCE PERIODS: are missing, not well specified, or in conflict	**YES**	**NO**
STEP 4 - ASSUMPTIONS: Determine if there are problems with assumptions made or the underlying logic.		
4a) INNAPPROPRIATE ASSUMPTIONS: are made about the respondent or about his / her living situation.	**YES**	**NO**
4b) ASSUMES CONSTANT BEHAVIOUR: or experience for situations that vary	**YES**	**NO**
4c) DOUBLE BARRELED: Contains more than one implicit question. Again the word access here is causing a double barrel.	**YES**	**NO**

STEP 5 – KNOWLEDGE/MEMORY: Check whether respondents are likely to *not know* or have trouble *remembering* information		
5a) KNOWLEDGE may not exist: Respondent is unlikely to know the answer to a factual question.	**YES**	**NO**
5b) ATTITUDE may not exist: Respondent is unlikely to have formed the attitude being asked about.	**YES**	**NO**
5c) RECALL failure: Respondent may not remember the information asked for	**YES**	**NO**
5d) COMPUTATION problem: The question requires a difficult mental calculation	**YES**	**NO**
STEP 6 - SENSITIVITY /BIAS: Access questions for sensitive nature or wording, and for bias		
6a) SENSITIVE CONTEXT (general): The question asks about how a topic that is embarrassing, very private, or that involves illegal behaviour.	**YES**	**NO**
6b) sensitive wording (specific) Given that the general topic is sensitive , the wording should be improved to minimise sensitivity.	**YES**	**NO**
6c) SOCIALLY ACCEPTABLE response is implied by the questions	**YES**	**NO**
STEP 7 - RESPONSE CATERGORIES : Access the adequacy of the range of response to be accorded		
7a) OPEN ENDED QUESTIONS That is inappropriate or difficult	**YES**	**NO**
7b) MISMATCH between question & response categories	**YES**	**NO**
7c) TECHNICAL TERMS are unclear, undefined or complex	**YES**	**NO**
7d) VAGUE response categories are subject to multiple interpretations	**YES**	**NO**
7e) OVERLAPPING response categories.	**YES**	**NO**
7f) MISSING eligible responses in response categories	**YES**	**NO**
7g) ILLOGICAL ORDER of response categories	**YES**	**NO**
STEP 8 – OTHER PROBLEMS: Look for problems not identified in steps 1 – 7		
8a) Other problems not previously identified	**YES**	**NO**

Q 2

Question Appraisal System (QAS-99)

Coding Form

Instructions: Use form for each question to be reviewed.

1) **Write in Question.**

Q2.Making Informed Decisions about Care
Were you offered choices around treatment options and services Did you get enough information around treatment and services Did you get enough information about peer support groups (SMART, family support peer groups, AA, NA, Al-Anon) Were you notified of cost (if any)?

2) **Circle or highlight YES or NO for each problem type (1a.....8)**
3) **Whenever a YES is circled, write detailed notes on this on this form that describes the problem**

Step 1. Reading determine if it is difficult for the interviewers to read the question uniformly to all respondents		
1a) WHAT TO READ: Interviewers may have difficulty determining what parts of the question should be read	YES	NO
1b) MISSING INFORMATION: Information to the interviewer needs to administer the question not contained in the question	YES	NO
1c)HOW TO READ: Question is not fully scripted & therefore difficult to read	YES	NO
STEP 2. INSTRUCTIONS: Look for problems with any introductions, instructions, or explanations from the *respondent's* point of view		
2a) CONFLICTING OR INNACURATE INSTRUCTIONS, introduction or explanations	YES	NO
2b)COMPLICATED INSTRUCTIONS, introductions or explanations	YES	NO
STEP 3- CLARITY: Identify problems related to communicating the intent or meaning of the question to the *respondent*		
3a) WORDING: Question is lengthy, awkward, ungrammatical or contains complicated syntax	YES	NO
3b) TECHNICAL TERMS: are undefined, unclear, or complex	YES	NO
3c) VAGUE: There are multiple ways to interpret the question or to decide what is to be included or excluded	YES	NO
3d) REFERENCEPERIODS: are missing, not well specified, or in conflict	YES	NO
STEP 4 - ASSUMPTIONS: Determine if there are problems with assumptions made or the underlying logic		
4a) INNAPPROPRIATE ASSUMPTIONS: are made about the respondent or about his / her living situation	YES	NO
4b) ASSUMES CONSTANT BEHAVIOUR: or experience for situations that vary	YES	NO
4c) DOUBLE BARRELED: Contains more than one implicit question	YES	NO
STEP 5 – KNOWLEDGE/MEMORY: Check whether respondents are likely to *not know* or have trouble *remembering* information		
5a) KNOWLEDGE may not exist: Respondent is unlikely to know the answer to a factual question	YES	NO
5b) ATTITUDE may not exist: Respondent is unlikely to have formed the attitude being asked about	YES	NO
5c) RECALL failure: Respondent may not remember the information asked for	YES	NO
5d) COMPUTATION problem: The question requires a difficult mental calculation	YES	NO
STEP 6 - SENSITIVITY /BIAS: Access questions for sensitive nature or wording, and for bias		
6a) SENSITIVE CONTEXT (general): The question asks about how a topic that is embarrassing, very private, or that involves illegal behaviour	YES	NO
6b) SENSITIVE WORDING (specific) Given that the general topic is sensitive, the wording should be improved to minimise sensitivity	YES	NO
6c) SOCIALLY ACCEPTABLE response is implied by the questions	YES	NO
STEP 7 - RESPONSE CATERGORIES : Access the adequacy of the range of response to be accorded		
7a) OPEN ENDED QUESTIONS That is inappropriate or difficult	YES	NO
7b) MISMATCH between question & response categories	YES	NO
7c) TECHNICAL TERMS are unclear, undefined or complex	YES	NO

7d) VAGUE response categories are subject to multiple interpretations	YES	NO
7e) OVERLAPPING response categories	YES	NO
7f) MISSING eligible responses in response categories	YES	NO
7g) ILLOGICAL ORDER of response categories	YES	NO
STEP 8 – OTHER PROBLEMS: Look for problems not identified in steps 1 – 7		
8a) Other problems not previously identified	YES	NO

Q 3

Question Appraisal System (QAS-99)

Coding Form

Instructions: Use form for each question to be reviewed.

1) **Write in Question.**

Q3 Respect for Patient Centred Values, Needs & Preferences
Was your involvement encouraged in key decisions about your care? Were you given a choice in terms of time & date of appointment?

2) **Circle or highlight YES or NO for each problem type (1a.....8)**
3) **Whenever a YES is circled, write detailed notes on this on this form that describes the problem**

Step 1. Reading determine if it is difficult for the interviewers to read the question uniformly to all respondents		
1a) WHAT TO READ: Interviewers may have difficulty determining what parts of the question should be read	YES	NO
1b) MISSING INFORMATION: Information to the interviewer needs to administer the question not contained in the question	YES	NO
1c)HOW TO READ: Question is not fully scripted & therefore difficult to read	YES	NO
STEP 2. INSTRUCTIONS: Look for problems with any introductions, instructions, or explanations from the *respondent's* point of view		
2a) CONFLICTING OR INNACURATE INSTRUCTIONS, introduction or explanations	YES	NO
2b)COMPLICATED INSTRUCTIONS, introductions or explanations	YES	NO
STEP 3- CLARITY: Identify problems related to communicating the intent or meaning of the question to the *respondent*		
3a) WORDING: Question is lengthy, awkward, ungrammatical or contains complicated syntax	YES	NO
3b) TECHNICAL TERMS: are undefined, unclear, or complex	YES	NO
3c) VAGUE: There are multiple ways to interpret the question or to decide what is to be included or excluded	YES	NO
3d) REFERENCEPERIODS: are missing, not well specified, or in conflict	YES	NO
STEP 4 - ASSUMPTIONS: Determine if there are problems with assumptions made or the underlying logic		
4a) INNAPPROPRIATE ASSUMPTIONS: are made about the respondent or about his / her living situation	YES	NO
4b) ASSUMES CONSTANT BEHAVIOUR: or experience for situations that vary	YES	NO

4c) DOUBLE BARRELED: Contains more than one implicit question	YES	NO
STEP 5 – KNOWLEDGE/MEMORY: Check whether respondents are likely to *not know* or have trouble *remembering* information		
5a) KNOWLEDGE may not exist: Respondent is unlikely to know the answer to a factual question	YES	NO
5b) ATTITUDE may not exist: Respondent is unlikely to have formed the attitude being asked about	YES	NO
5c) RECALL failure: Respondent may not remember the information asked for	YES	NO
5d) COMPUTATION problem: The question requires a difficult mental calculation	YES	NO
STEP 6 - SENSITIVITY /BIAS: Access questions for sensitive nature or wording, and for bias		
6a) SENSITIVE CONTEXT (general): The question asks about how a topic that is embarrassing, very private, or that involves illegal behaviour	YES	NO
6b) sensitive wording (specific) Given that the general topic is sensitive , the wording should be improved to minimise sensitivity	YES	NO
6c) SOCIALLY ACCEPTABLE response is implied by the questions	YES	NO
STEP 7 - RESPONSE CATERGORIES : Access the adequacy of the range of response to be accorded		
7a) OPEN ENDED QUESTIONS That is inappropriate or difficult	YES	NO
7b) MISMATCH between question & response categories	YES	NO
7c) TECHNICAL TERMS are unclear, undefined or complex	YES	NO
7d) VAGUE response categories are subject to multiple interpretations	YES	NO
7e) OVERLAPPING response categories	YES	NO
7f) MISSING eligible responses in response categories	YES	NO
7g) ILLOGICAL ORDER of response categories	YES	NO
STEP 8 – OTHER PROBLEMS: Look for problems not identified in steps 1 – 7		
8a) Other problems not previously identified	YES	NO

Q 4

Question Appraisal System (QAS-99)

Coding Form

Instructions: Use form for each question to be reviewed.

1) **Write in Question.**

Q4 Maintaining & Improving own Health & Well being
Were you given information that would help you improve your health and wellbeing?

2) **Circle or highlight YES or NO for each problem type (1a.....8)**
3) **Whenever a YES is circled, write detailed notes on this on this form that describes the problem**

Step 1. Reading determine if it is difficult for the interviewers to read the question uniformly to all respondents		
1a) WHAT TO READ: Interviewers may have difficulty determining what	YES	NO

parts of the question should be read		
1b) MISSING INFORMATION: Information to the interviewer needs to administer the question not contained in the question	**YES**	**NO**
1c)HOW TO READ: Question is not fully scripted & therefore difficult to read	**YES**	**NO**
STEP 2. INSTRUCTIONS: Look for problems with any introductions, instructions, or explanations from the *respondent's* point of view		
2a) CONFLICTING OR INNACURATE INSTRUCTIONS, introduction or explanations	**YES**	**NO**
2b)COMPLICATED INSTRUCTIONS, introductions or explanations	**YES**	**NO**
STEP 3- CLARITY: Identify problems related to communicating the intent or meaning of the question to the *respondent*		
3a) WORDING: Question is lengthy, awkward, ungrammatical or contains complicated syntax	**YES**	**NO**
3b) TECHNICAL TERMS: are undefined, unclear, or complex	**YES**	**NO**
3c) VAGUE: There are multiple ways to interpret the question or to decide what is to be included or excluded	**YES**	**NO**
3d) REFERENCEPERIODS: are missing, not well specified, or in conflict	**YES**	**NO**
STEP 4 - ASSUMPTIONS: Determine if there are problems with assumptions made or the underlying logic.		
4a) INNAPPROPRIATE ASSUMPTIONS: are made about the respondent or about his / her living situation	**YES**	**NO**
4b) ASSUMES CONSTANT BEHAVIOUR: or experience for situations that vary	**YES**	**NO**
4c) DOUBLE BARRELED: Contains more than one implicit question	**YES**	**NO**
STEP 5 – KNOWLEDGE/MEMORY: Check whether respondents are likely to *not know* or have trouble *remembering* information		
5a) KNOWLEDGE may not exist: Respondent is unlikely to know the answer to a factual question	**YES**	**NO**
5b) ATTITUDE may not exist: Respondent is unlikely to have formed the attitude being asked about	**YES**	**NO**
5c) RECALL failure: Respondent may not remember the information asked for	**YES**	**NO**
5d) COMPUTATION problem: The question requires a difficult mental calculation	**YES**	**NO**
STEP 6 - SENSITIVITY /BIAS: Access questions for sensitive nature or wording, and for bias		
6a) SENSITIVE CONTEXT (general): The question asks about how a topic that is embarrassing, very private, or that involves illegal behaviour	**YES**	**NO**
6b) sensitive wording (specific) Given that the general topic is sensitive , the wording should be improved to minimise sensitivity	**YES**	**NO**
6c) SOCIALLY ACCEPTABLE response is implied by the questions	**YES**	**NO**
STEP 7 - RESPONSE CATERGORIES : Access the adequacy of the range of response to be accorded		
7a) OPEN ENDED QUESTIONS That is inappropriate or difficult	**YES**	**NO**
7b) MISMATCH between question & response categories	**YES**	**NO**
7c) TECHNICAL TERMS are unclear, undefined or complex	**YES**	**NO**
7d) VAGUE response categories are subject to multiple interpretations	**YES**	**NO**

7e) OVERLAPPING response categories	YES	NO
7f) MISSING eligible responses in response categories	YES	NO
7g) ILLOGICAL ORDER of response categories	YES	NO
STEP 8 – OTHER PROBLEMS: Look for problems not identified in steps 1 – 7		
8a) Other problems not previously identified	YES	NO

Q 5

Question Appraisal System (QAS-99)

Coding Form

Instructions: Use form for each question to be reviewed.

1) **Write in Question.**

Q 5.Informed Consent
Was consent explained to you? Were you asked to sign a consent form? Were your rights explained to you regarding data protection & confidentiality? Were you asked to renew consent (if you have been in treatment for more than 3 months)?

2) **Circle or highlight YES or NO for each problem type (1a.....8)**
3) **Whenever a YES is circled, write detailed notes on this on this form that describes the problem**

Step 1. Reading determine if it is difficult for the interviewers to read the question uniformly to all respondents		
1a) WHAT TO READ: Interviewers may have difficulty determining what parts of the question should be read	**YES**	**NO**
1b) MISSING INFORMATION: Information to the interviewer needs to administer the question not contained in the question	**YES**	**NO**
1c)HOW TO READ: Question is not fully scripted & therefore difficult to read	**YES**	**NO**
STEP 2. INSTRUCTIONS: Look for problems with any introductions, instructions, or explanations from the *respondent's* point of view		
2a) CONFLICTING OR INNACURATE INSTRUCTIONS, introduction or explanations	**YES**	**NO**
2b)COMPLICATED INSTRUCTIONS, introductions or explanations	**YES**	**NO**
STEP 3- CLARITY: Identify problems related to communicating the intent or meaning of the question to the *respondent*		
3a) WORDING: Question is lengthy, awkward, ungrammatical or contains complicated syntax	**YES**	**NO**
3b) TECHNICAL TERMS: are undefined, unclear, or complex	**YES**	**NO**
3c) VAGUE: There are multiple ways to interpret the question or to decide what is to be included or excluded	**YES**	**NO**
3d) REFERENCEPERIODS: are missing, not well specified, or in conflict	**YES**	**NO**
STEP 4 - ASSUMPTIONS: Determine if there are problems with assumptions made or the underlying logic.		

4a) INNAPPROPRIATE ASSUMPTIONS: are made about the respondent or about his / her living situation	**YES**	**NO**
4b) ASSUMES CONSTANT BEHAVIOUR: or experience for situations that vary	**YES**	**NO**
4c) DOUBLE BARRELED: Contains more than one implicit question	**YES**	**NO**
STEP 5 – KNOWLEDGE/MEMORY: Check whether respondents are likely to *not know* or have trouble *remembering* information		
5a) KNOWLEDGE may not exist: Respondent is unlikely to know the answer to a factual question	**YES**	**NO**
5b) ATTITUDE may not exist: Respondent is unlikely to have formed the attitude being asked about	**YES**	**NO**
5c) RECALL failure: Respondent may not remember the information asked for	**YES**	**NO**
5d) COMPUTATION problem: The question requires a difficult mental calculation	**YES**	**NO**
STEP 6 - SENSITIVITY /BIAS: Access questions for sensitive nature or wording, and for bias		
6a) SENSITIVE CONTEXT (general): The question asks about how a topic that is embarrassing, very private, or that involves illegal behaviour	**YES**	**NO**
6b) sensitive wording (specific) Given that the general topic is sensitive , the wording should be improved to minimise sensitivity	**YES**	**NO**
6c) SOCIALLY ACCEPTABLE response is implied by the questions	**YES**	**NO**
STEP 7 - RESPONSE CATERGORIES : Access the adequacy of the range of response to be accorded		
7a) OPEN ENDED QUESTIONS That is inappropriate or difficult	**YES**	**NO**
7b) MISMATCH between question & response categories	**YES**	**NO**
7c) TECHNICAL TERMS are unclear, undefined or complex	**YES**	**NO**
7d) VAGUE response categories are subject to multiple interpretations	**YES**	**NO**
7e) OVERLAPPING response categories	**YES**	**NO**
7f) MISSING eligible responses in response categories	**YES**	**NO**
7g) ILLOGICAL ORDER of response categories	**YES**	**NO**
STEP 8 – OTHER PROBLEMS: Look for problems not identified in steps 1 – 7		
8a) Other problems not previously identified	**YES**	**NO**

Q 6

Question Appraisal System (QAS-99)

Coding Form

Instructions: Use form for each question to be reviewed.

1) **Write in Question.**

Q6 Kindness, Consideration & Respect
Did you feel that you were listened too? Did the service communicate in a way that you understood? Were you ever treated in a discourteous manner? Do you know where to bring a concern/complaint? If you have made a complaint, were you satisified in the way it was handled?

2) **Circle or highlight YES or NO for each problem type (1a.....8)**
3) **Whenever a YES is circled, write detailed notes on this on this form that describes the problem**

Step 1. Reading determine if it is difficult for the interviewers to read the question uniformly to all respondents		
1a) WHAT TO READ: Interviewers may have difficulty determining what parts of the question should be read	**YES**	**NO**
1b) MISSING INFORMATION: Information to the interviewer needs to administer the question not contained in the question	**YES**	**NO**
1c)HOW TO READ: Question is not fully scripted & therefore difficult to read	**YES**	**NO**
STEP 2. INSTRUCTIONS: Look for problems with any introductions, instructions, or explanations from the *respondents's* point of view		
2a) CONFLICTING OR INNACURATE INSTRUCTIONS, introduction or explanations	**YES**	**NO**
2b)COMPLICATED INSTRUCTIONS, introductions or explanations	**YES**	**NO**
STEP 3- CLARITY: Identify problems related to communicating the intent or meaning of the question to the *respondent*		
3a) WORDING: Question is lengthy, awkward, ungrammatical or contains complicated syntax	**YES**	**NO**
3b) TECHNICAL TERMS: are undefined, unclear, or complex	**YES**	**NO**
3c) VAGUE: There are multiple ways to interpret the question or to decide what is to be included or excluded	**YES**	**NO**
3d) REFERENCEPERIODS: are missing, not well specified, or in conflict	**YES**	**NO**
STEP 4 - ASSUMPTIONS: Determine if there are problems with assumptions made or the underlying logic.		
4a) INNAPPROPRIATE ASSUMPTIONS: are made about the respondent or about his / her living situation	**YES**	**NO**
4b) ASSUMES CONSTANT BEHAVIOUR: or experience for situations that vary	**YES**	**NO**
4c) DOUBLE BARRELED: Contains more than one implicit question	**YES**	**NO**
STEP 5 – KNOWLEDGE/MEMORY: Check whether respondents are likely to *not know* or have trouble *remembering* information		
5a) KNOWLEDGE may not exist: Respondent is unlikely to know the answer to a factual question	**YES**	**NO**
5b) ATTITUDE may not exist: Respondent is unlikely to have formed the attitude being asked about	**YES**	**NO**
5c) RECALL failure: Respondent may not remember the information asked for	**YES**	**NO**
5d) COMPUTATION problem: The question requires a difficult mental calculation	**YES**	**NO**
STEP 6 - SENSITIVITY /BIAS: Access questions for sensitive nature or wording, and for bias		
6a) SENSITIVE CONTEXT (general): The question asks about how a topic that is embarrassing, very private, or that involves illegal behaviour	**YES**	**NO**
6b) sensitive wording (specific) Given that the general topic is sensitive , the wording should be improved to minimise sensitivity	**YES**	**NO**
6c) SOCIALLY ACCEPTABLE response is implied by the questions	**YES**	**NO**

STEP 7 - RESPONSE CATERGORIES : Access the adequacy of the range of response to be accorded		
7a) OPEN ENDED QUESTIONS That is inappropriate or difficult	**YES**	**NO**
7b) MISMATCH between question & response categories	**YES**	**NO**
7c) TECHNICAL TERMS are unclear, undefined or complex	**YES**	**NO**
7d) VAGUE response categories are subject to multiple interpretations	**YES**	**NO**
7e) OVERLAPPING response categories	**YES**	**NO**
7f) MISSING eligible responses in response categories	**YES**	**NO**
7g) ILLOGICAL ORDER of response categories	**YES**	**NO**
STEP 8 – OTHER PROBLEMS: Look for problems not identified in steps 1 – 7		
8a) Other problems not previously identified	**YES**	**NO**

Q 7

Question Appraisal System (QAS-99)

Coding Form

Instructions: Use form for each question to be reviewed.

1) **Write in Question.**

Q 7 Dignity Privacy & Autonomy
Were you provided privacy when needed?

2) **Circle or highlight YES or NO for each problem type (1a.....8)**
3) **Whenever a YES is circled, write detailed notes on this on this form that describes the problem**

Step 1. Reading determine if it is difficult for the interviewers to read the question uniformly to all respondents		
1a) WHAT TO READ: Interviewers may have difficulty determining what parts of the question should be read	**YES**	**NO**
1b) MISSING INFORMATION: Information to the interviewer needs to administer the question not contained in the question	**YES**	**NO**
1c)HOW TO READ: Question is not fully scripted & therefore difficult to read	**YES**	**NO**
STEP 2. INSTRUCTIONS: Look for problems with any introductions, instructions, or explanations from the *respondents's* point of view		
2a) CONFLICTING OR INNACURATE INSTRUCTIONS, introduction or explanations	**YES**	**NO**
2b)COMPLICATED INSTRUCTIONS, introductions or explanations	**YES**	**NO**
STEP 3- CLARITY: Identify problems related to communicating the intent or meaning of the question to the *respondent*		
3a) WORDING: Question is lengthy, awkward, ungrammatical or contains complicated syntax	**YES**	**NO**
3b) TECHNICAL TERMS: are undefined, unclear, or complex	**YES**	**NO**
3c) VAGUE: There are multiple ways to interpret the question or to decide what is to be included or excluded	**YES**	**NO**
3d) REFERENCEPERIODS: are missing, not well specified, or in conflict	**YES**	**NO**

STEP 4 - ASSUMPTIONS: Determine if there are problems with assumptions made or the underlying logic		
4a) INNAPPROPRIATE ASSUMPTIONS: are made about the respondent or about his / her living situation	**YES**	**NO**
4b) ASSUMES CONSTANT BEHAVIOUR: or experience for situations that vary	**YES**	**NO**
4c) DOUBLE BARRELED: Contains more than one implicit question	**YES**	**NO**
STEP 5 – KNOWLEDGE/MEMORY: Check whether respondents are likely to *not know* or have trouble *remembering* information		
5a) KNOWLEDGE may not exist: Respondent is unlikely to know the answer to a factual question	**YES**	**NO**
5b) ATTITUDE may not exist: Respondent is unlikely to have formed the attitude being asked about	**YES**	**NO**
5c) RECALL failure: Respondent may not remember the information asked for	**YES**	**NO**
5d) COMPUTATION problem: The question requires a difficult mental calculation	**YES**	**NO**
STEP 6 - SENSITIVITY /BIAS: Access questions for sensitive nature or wording, and for bias		
6a) SENSITIVE CONTEXT (general): The question asks about how a topic that is embarrassing, very private, or that involves illegal behaviour	**YES**	**NO**
6b) sensitive wording (specific) Given that the general topic is sensitive , the wording should be improved to minimise sensitivity	**YES**	**NO**
6c) SOCIALLY ACCEPTABLE response is implied by the questions	**YES**	**NO**
STEP 7 - RESPONSE CATERGORIES : Access the adequacy of the range of response to be accorded		
7a) OPEN ENDED QUESTIONS That is inappropriate or difficult	**YES**	**NO**
7b) MISMATCH between question & response categories	**YES**	**NO**
7c) TECHNICAL TERMS are unclear, undefined or complex	**YES**	**NO**
7d) VAGUE response categories are subject to multiple interpretations	**YES**	**NO**
7e) OVERLAPPING response categories	**YES**	**NO**
7f) MISSING eligible responses in response categories	**YES**	**NO**
7g) ILLOGICAL ORDER of response categories	**YES**	**NO**
STEP 8 – OTHER PROBLEMS: Look for problems not identified in steps 1 – 7		
8a) Other problems not previously identified	**YES**	**NO**

Q 8

Question Appraisal System (QAS-99)

Coding Form

Instructions: Use form for each question to be reviewed.

1) **Write in Question.**

Respecting Diversity & Protecting Rights
Did you feel that the service respected your lifestyle choices?

Did you feel that the service responded to circumstances of your life/family background and culture?
Is there a specific comment that you would like to add on this?

____

2) **Circle or highlight YES or NO for each problem type (1a.....8)**
3) **Whenever a YES is circled, write detailed notes on this on this form that describes the problem**

Step 1. Reading determine if it is difficult for the interviewers to read the question uniformly to all respondents		
1a) WHAT TO READ: Interviewers may have difficulty determining what parts of the question should be read	**YES**	**NO**
1b) MISSING INFORMATION: Information to the interviewer needs to administer the question not contained in the question	**YES**	**NO**
1c) HOW TO READ: Question is not fully scripted & therefore difficult to read	**YES**	**NO**
STEP 2. INSTRUCTIONS: Look for problems with any introductions, instructions, or explanations from the *respondent's* point of view		
2a) CONFLICTING OR INNACURATE INSTRUCTIONS, introduction or explanations	**YES**	**NO**
2b) COMPLICATED INSTRUCTIONS, introductions or explanations	**YES**	**NO**
STEP 3- CLARITY: Identify problems related to communicating the intent or meaning of the question to the *respondent*		
3a) WORDING: Question is lengthy, awkward, ungrammatical or contains complicated syntax	**YES**	**NO**
3b) TECHNICAL TERMS: are undefined, unclear, or complex	**YES**	**NO**
3c) VAGUE: There are multiple ways to interpret the question or to decide what is to be included or excluded	**YES**	**NO**
3d) REFERENCEPERIODS: are missing, not well specified, or in conflict	**YES**	**NO**
STEP 4 - ASSUMPTIONS: Determine if there are problems with assumptions made or the underlying logic.		
4a) INNAPPROPRIATE ASSUMPTIONS: are made about the respondent or about his / her living situation	**YES**	**NO**
4b) ASSUMES CONSTANT BEHAVIOUR: or experience for situations that vary	**YES**	**NO**
4c) DOUBLE BARRELED: Contains more than one implicit question	**YES**	**NO**
STEP 5 – KNOWLEDGE/MEMORY: Check whether respondents are likely to *not know* or have trouble *remembering* information		
5a) KNOWLEDGE may not exist: Respondent is unlikely to know the answer to a factual question	**YES**	**NO**
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6c) SOCIALLY ACCEPTABLE response is implied by the questions	**YES**	**NO**
STEP 7 - RESPONSE CATERGORIES : Access the adequacy of the range of response to be accorded		
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7e) OVERLAPPING response categories	**YES**	**NO**
7f) MISSING eligible responses in response categories	**YES**	**NO**
7g) ILLOGICAL ORDER of response categories	**YES**	**NO**
STEP 8 – OTHER PROBLEMS: Look for problems not identified in steps 1 – 7		
8a) Other problems not previously identified	**YES**	**NO**

Appendix 7: Implementation guidelines

Service User Experience Survey Implementation plan

(Following NAAGG meetings, February & March 2017)

During 2016 NAAGG developed a Service User experience tool to assist in delivering on Theme 1 of the National Standards for Safer Better Health, Person Centred Care and Support. This has built on previous surveys carried out by CHOs and has been piloted and tested with services users with the assistance of UISCE.

It is intended that the service experience survey will:

1. Provide a baseline of patients' experience for Addiction Services.
2. Inform national service objectives.
3. Assist CHOs to:
    - Inform service planning and identify priorities annually from a Service User perspective.
    - Identify quality improvements.
4. Enhance Service User involvement.
5. Enhance staff performance.

As discussed at NAAGG, a suggested implementation plan for CHOs in rolling out the survey is as follows:

Phase	**Action**
Preparation	Chose a month to conduct the survey in your services(s)
	Print copies of the questionnaire – ideally 2 sided
	Print posters for the notice board/waiting area indicating when the survey will take place and how to participate
	Select staff to facilitate the questionnaire *Consider using staff from different services to facilitate the survey on chosen dates in services they are not directly involved in. This is to enable the Service Users to answer the questionnaire openly and anonymously.*
	Chose dates for the facilitated questionnaires in services
	For non-facilitated surveys, provide envelopes and prepare a secure box for the completed questionnaires or use the existing feedback box
Survey	Poster on notice board/waiting area
	Leave copies of the questionnaire and envelopes in the waiting room
	Questionnaire facilitators in place in services as per plan
	Nominate person to collect the completed surveys *At regular intervals or at the end of the month*
Results	Nominate person to collate the results of the survey
	Provide feedback to Service Users on the results of the survey *The questionnaire indicates that the results will be provided on the notice board*
	Provide feedback to CHO area operational and governance group, for example potential risks, staff training needs etc
	Provide feedback to the National Social Inclusion Office through the NAAGG.

Appendix 8: Service User Experience Survey

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Code

HSE Drug and Alcohol Services

Please tell us what you think

This service is running an anonymous survey to ask about
YOUR EXPERIENCE OF THIS SERVICE

Speak up and help make our Drug and Alcohol services better for you and for others.

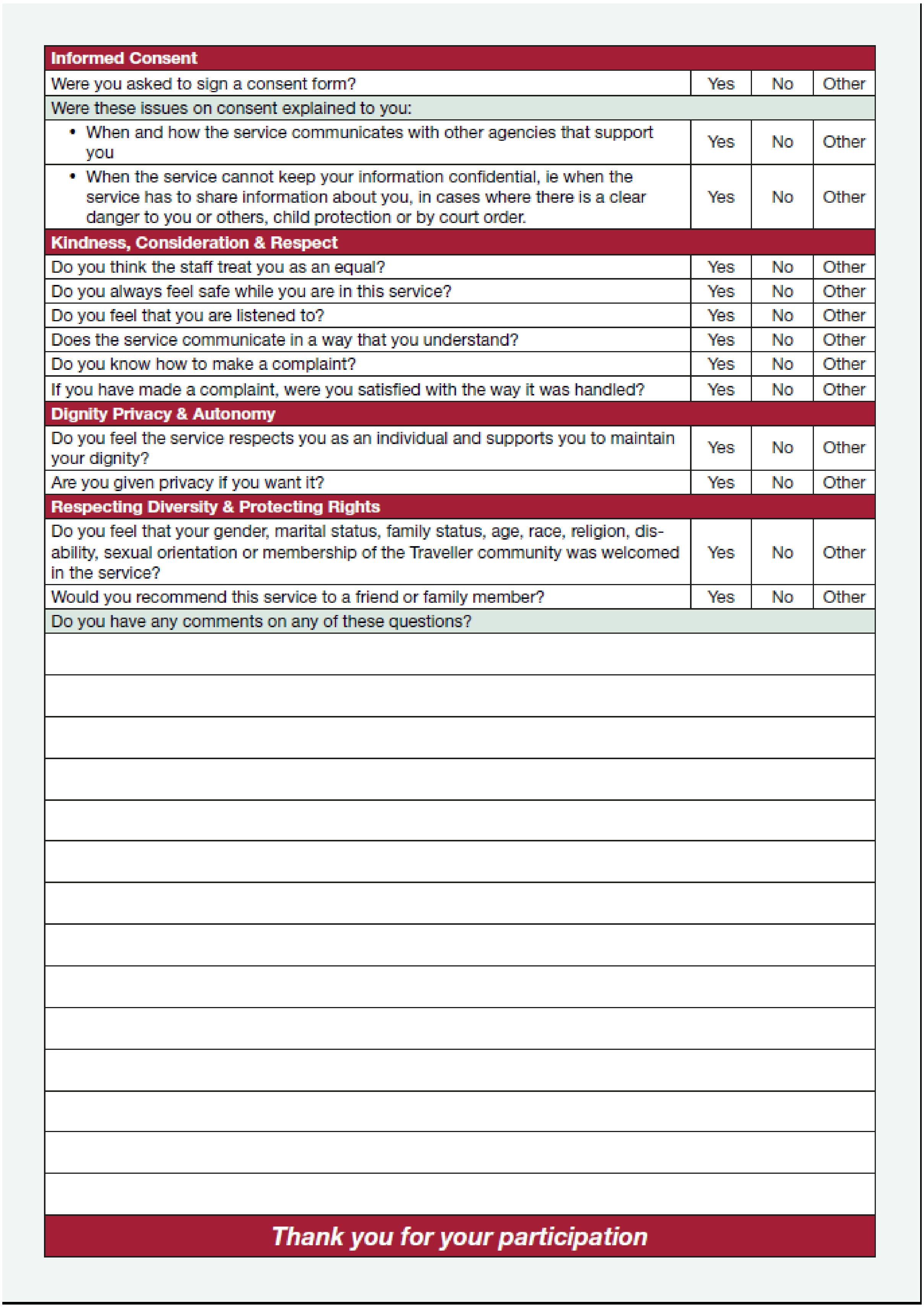
Your feedback is greatly appreciated.

Your answers are **ANONYMOUS – you are not asked for your name.**

The results and how we respond to your experiences will be posted on the notice board.

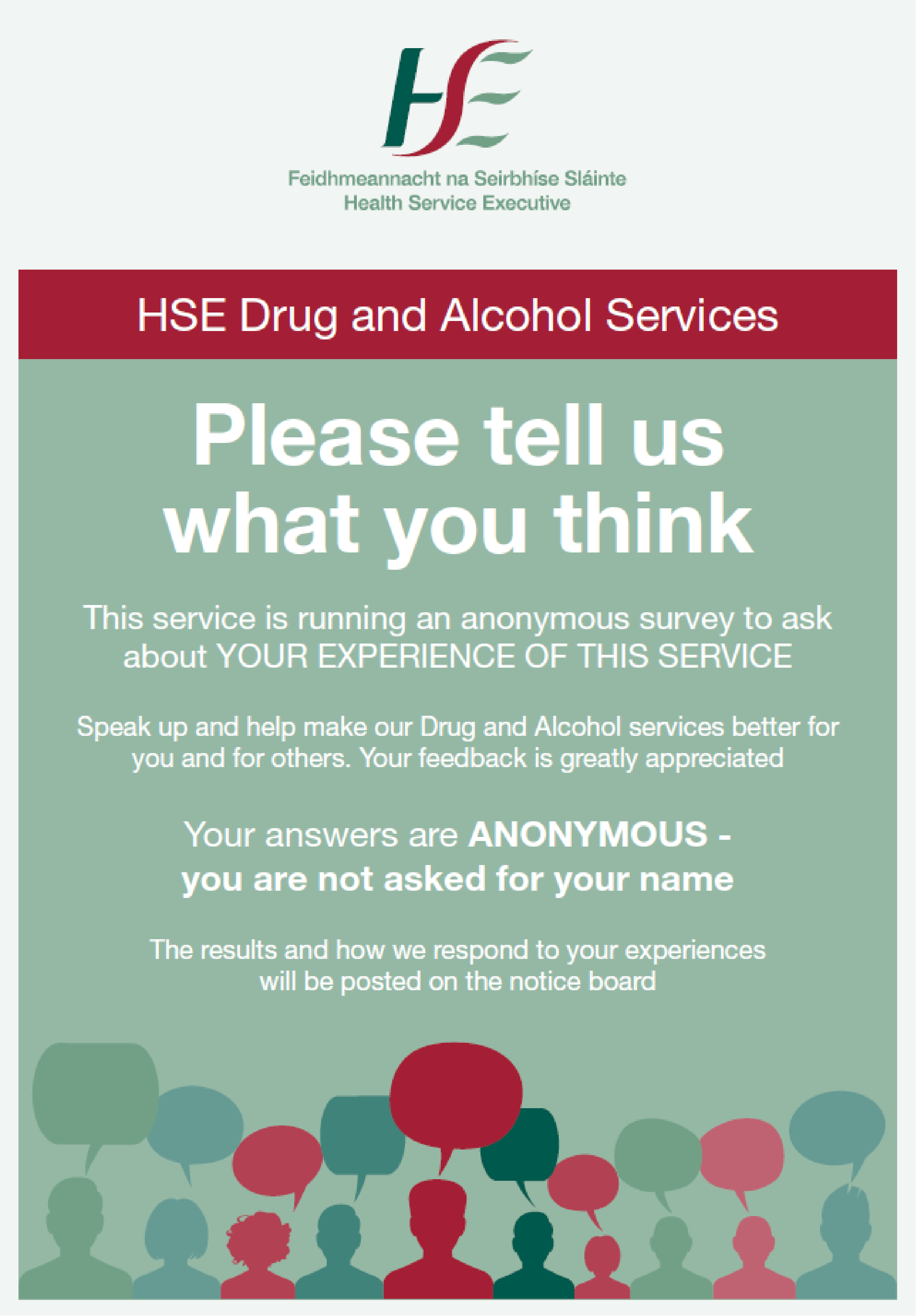
Drug and Alcohol Services National Service User Experience Survey

Access to Services			
When you were ready, did you know where to go to get help?	Yes	No	Other
Was this treatment service your first choice?	Yes	No	Other
Was it clear to you how to get in to this treatment service?	Yes	No	Other
Making Informed Decisions about Care			
Were you given enough information about this treatment services, such as			
• Cost	Yes	No	Other
• Length of time you would be part of this programme	Yes	No	Other
• How many appointments you would have	Yes	No	Other
• What would happen if you had a slip or missed appointments	Yes	No	Other
Were you given enough information about peer support groups (for example SMART, family support peer groups, AA, NA, Al-Anon)?	Yes	No	Other
Respect for Patient Centered Values, Needs & Preferences			
Do the staff take the time to get to know you and your expectations?	Yes	No	Other
Do you feel involved in your care plan?	Yes	No	Other
Are you able to make appointments for a time that suits you?	Yes	No	Other
Do you feel like you have options – is the service flexible if something doesn't suit you?	Yes	No	Other
Maintaining & Improving own Health & Wellbeing			
This service is working towards a 'Healthy Ireland' where everyone can enjoy physical and mental health and wellbeing to their full potential. Are we encouraging you to make positive changes to the following?			
• Alcohol use	Yes	No	Other
• Drug use	Yes	No	Other
• Smoking	Yes	No	Other
• Eating	Yes	No	Other
• Physical exercise	Yes	No	Other
• Sexual health	Yes	No	Other
• Mental health and wellbeing	Yes	No	Other



Informed Consent			
Were you asked to sign a consent form?	Yes	No	Other
Were these issues on consent explained to you:			
• When and how the service communicates with other agencies that support you	Yes	No	Other
• When the service cannot keep your information confidential, ie when the service has to share information about you, in cases where there is a clear danger to you or others, child protection or by court order.	Yes	No	Other
Kindness, Consideration & Respect			
Do you think the staff treat you as an equal?	Yes	No	Other
Do you always feel safe while you are in this service?	Yes	No	Other
Do you feel that you are listened to?	Yes	No	Other
Does the service communicate in a way that you understand?	Yes	No	Other
Do you know how to make a complaint?	Yes	No	Other
If you have made a complaint, were you satisfied with the way it was handled?	Yes	No	Other
Dignity Privacy & Autonomy			
Do you feel the service respects you as an individual and supports you to maintain your dignity?	Yes	No	Other
Are you given privacy if you want it?	Yes	No	Other
Respecting Diversity & Protecting Rights			
Do you feel that your gender, marital status, family status, age, race, religion, disability, sexual orientation or membership of the Traveller community was welcomed in the service?	Yes	No	Other
Would you recommend this service to a friend or family member?	Yes	No	Other
Do you have any comments on any of these questions?			
Thank you for your participation			

Appendix 9: Service User Experience Survey poster



Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

HSE Drug and Alcohol Services

Please tell us what you think

This service is running an anonymous survey to ask about YOUR EXPERIENCE OF THIS SERVICE

Speak up and help make our Drug and Alcohol services better for you and for others. Your feedback is greatly appreciated

Your answers are **ANONYMOUS - you are not asked for your name**

The results and how we respond to your experiences will be posted on the notice board