DEVELOPMENT REPORT FOR THE NATIONAL HEAR & TREAT AMBULANCE QUESTIONNAIRE

THE CO-ORDINATION CENTRE FOR THE NHS PATIENT SURVEY PROGRAMME

picker Institute Europe

Making patients' views count

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Contents

1 Introduction

This report details the development of the first ever National Ambulance Hear and Treat Service Users Survey in England. The development process commenced in Summer 2012 and was completed in Autumn 2013. It included a number of distinct stages, each of which will be explained thoroughly in this report.

The 2014 National Ambulance Service Users Survey took place during February-March 2014 and focused on 'hear and treat' service users. These are service users who have called 999 for non-life threatening situations or conditions, and who can receive triage or medical advice over the telephone by the ambulance service to manage their condition.

The methodology differed from other surveys in the National NHS Patient Survey Programme. This survey was a telephone survey conducted by TNS BMRB, and was administered to a sample of approximately 1000 hear and treat service users from each of the ten ambulance trusts[1]. Isle of Wight NHS Trust was the one ambulance trust not included in the survey as they treated too few hear and treat service users each month[2]. Trusts sent a census file of all of their hear and treat service users, who contacted the ambulance service directly (ie: by calling '999') during December 2013 - January 2014, from which the Coordination Centre selected a random sample of 1000 service users to send to colleagues at TNS. Sampled service users were offered an interview over the phone about their experience with the ambulance service.

The survey results provided ambulance trusts with information on hear and treat patient experience and service level comparisons. The Care Quality Commission (CQC) used national survey data for performance management of the ambulance trusts.

Summary of development

Development for this survey began with a feasibility study to determine whether it would be possible to develop and conduct a national survey of the target population. In determining the feasibility of the survey, a sampling pilot was undertaken with each ambulance trust to test the proposed methodological approach, and to refine what sample data would be available for a national survey. This pilot provided insight into the complications of the survey, but ultimately served to demonstrate the ability of trusts to participate. See Chapter 2.

After the sampling pilot, an extensive consultation with relevant stakeholders was undertaken. Stakeholders included policy experts at the Department of Health and NHS England, representatives from all ten trusts and with service users from across the country.

This consultation informed the development of the final questionnaire. Questionnaire development included input from diverse sources including service users, trusts and the CQC. The questionnaire underwent three rounds of rigorous testing with service users.

Concurrent to the questionnaire design phase was procurement of a telephone fieldwork agency. After interviewing a variety of candidates the Coordination Centre and CQC selected TNS BMRB.

[1] All trusts submitted a sample of 1,000 service users, however some were removed during sample cleaning meaning they were not included in the survey.

[2] The Isle of Wight is an NHS trust that includes an ambulance service along with Accident & Emergency and Acute services. It therefore is slightly different than all of the other ambulance trusts across England.

Additionally, this survey underwent rigorous ethical approval processes for the administration of the national survey and content of the questionnaire, along with gaining Section 251 Approval for the transfer of patient identifiable data.

2 Sampling Pilot

The aims of the sampling pilot were to:

- Establish whether and how a survey of hear and treat service users might be carried out.
- Determine how hear and treat service user records are held and their variability across ambulance trusts.
- Understand how many hear and treat service users are triaged by trusts in the course of one week.
- Identify any differences between trusts that could impact service user experience and thus influence the design and implementation of a national survey.

During the sampling pilot, the coordination centre liaised with the eleven ambulance trusts in England along with two national groups, namely representatives from the National Ambulance Service Patient Experience Group (NASPEG) and the National Ambulance Service Quality and Governance and Risk Directors (QGARD). During the sampling pilot, all those involved demonstrated support for a national survey.

This chapter will provide an introduction to hear and treat services, outline the sampling and methodological approach of the pilot, and conclude with a summary of the findings.

2.1 'Hear and treat' definition

'Hear and treat' refers to a categorisation of ambulance service users who receive advice over the phone rather than necessarily being attended by an ambulance crew.[1] This advice procedure is termed 'telephone triage' and refers specifically to the information and recommendations a service user receives from a call taker or clinician about their condition. This service is provided by all ambulance trusts across the country.

Whilst there are only a relatively small number of ambulance trusts, each of the trusts collect and record service user information using one of two different systems. The differences between these two systems posed challenges to collecting standardised samples for a national survey. Furthermore, the size of the service user population a trust serves varies greatly, which impacted upon the sampling approach and period necessary for each trust to draw a sufficiently large sample. These two issues will be covered in depth in the Sample Data Collection and Sampling Methodology sections respectively.

[1] Whilst in some hear and treat cases people's conditions escalate and services users are eventually attended by an ambulance crew, they originally will have undergone the telephone triage and advice process.

2.2 Sampling pilot background

As outlined earlier in this chapter, the sampling pilot had a number of aims. Each ambulance trust was asked to collect a census of callers who were deemed not to have life threatening conditions, otherwise known as Category Green 3 or Green 4 (G3 and G4) or hear and treat callers, dealt with during a one week period, 26th November- 2nd December 2012. Trusts were provided with standard guidance on how to collect the census, including the exclusion criteria to be applied (no under 16 year olds, no known deceased service users or service users with insufficient contact information for a telephone survey) to the census before submitting the final anonymised file to the coordination centre. Each ambulance trust was also asked to submit a feedback summary detailing the number of exclusions that had been made before submitting the final file, and to comment on the data source for each of the sampling variables. Trusts were also asked to comment on the actual process of drawing the sample in terms of resource burden on trust staff. Guidance was circulated to ambulance trusts two weeks in advance of the sampling period with regular contact from the coordination centre in the lead up to sample collection. Correspondence between ambulance trusts and the coordination centre was ongoing throughout the pilot and is summarised in the next section.

2.3 Sample data collection

The sample data items we would intend to collect for a national survey included the following:

1. Service user name[1].
2. Telephone number.
3. Gender.
4. Year of birth (or age where year of birth is not available).
5. Date of call.
6. Time of call.
7. Duration of call.
8. Diagnosis code/ condition information.
9. Who made the call (i.e. patient or third party).

All ambulance trusts gather service user information from the caller, whether patient or third party, throughout the telephone call. However, the mechanisms of recording this information vary. The primary difference is in the clinical triage and advice system that each trust uses, of which there are two in operation across the country. The first is Advanced Medical Priority Dispatch System (AMPDS) and the second system is NHS Pathways. The most notable difference is whether the initial call handler or a clinician undertakes detailed triage. For example, for the five trusts using NHS Pathways, usually the call taker will conduct a thorough series of triage assessments during the original call and classify the service user as hear and treat depending on the outcome of these assessments. For the six trusts using AMPDS, however, a service user will respond to a small number of clinical questions with a call taker and then normally receive a more detailed call back from a clinician within a given time frame[2]. The use of NHS Pathways or AMPDS also has implications for the type of service user information collected. The information that we have found

[1] For reasons of confidentiality, this information was not supplied to the Co-ordination Centre as part of each sample file in the sampling pilot. Trusts were instead asked to indicate how many records with insufficient contact information were removed during the sampling process.

[2] The time frame is normally determined by the severity of the service user's condition.

to be affected by differences in these systems includes age/ year of birth, call duration, and diagnoses codes.

2.3.1 Age and year of birth

For a national 'hear and treat' service users survey it would have been ideal to collect the caller's[1] year of birth rather than exact age, and only gather exact age where year of birth is not available. The callers year of birth is normally collected in the computer aided despatch system (CAD). However, it has become apparent that due to a number of different CAD systems in use across ambulance trusts it is not possible for every trust to collect caller's year of birth and very difficult to collect exact age information. The CAD system is separate from AMPDS or NHS Pathways operating systems and is used to help 999 call takers attend service users in the most appropriate way. CAD systems can be configured in a variety of different ways depending on how a trust programs it, but they all help determine how the 999 call should be handled based on input information from the call taker. CAD systems often store information relating to each call, however, this information is not uniform across trusts due to the different configurations. Therefore, some trusts were able to collect sample information like name or telephone number from their CAD systems for the sampling pilot. This means of gathering information was not mandatory; rather, trusts were asked to gather data fields from wherever they could and then report from where exactly they retrieved each field of data.

During the sample pilot and subsequent discussion period three NHS Pathways trusts explained that age information for callers is recorded as free text comments from original 999 calls. This required these trusts to manually extract age data from the CAD system and match it to the service users' electronic record in NHS Pathways. Due to the highly time consuming nature of the task, two NHS Pathways trusts did not complete the manual extraction process and obtained nothing more precise than an estimated age range. They also explained that the free text comments are often not standard across all cases and might include age information in vague formats (e.g. '60ish' 'young adult'). These two trusts were able to derive an approximate age range (e.g. '16+') from their CAD system which is programmed for the call taker to tick a box that says either 'adult,' 'child,' 'toddler,' 'neonate or infant.' These are the only options programmed into the CAD and the trusts cannot guarantee anything more precise. Ultimately these trusts can only provide a 'confident estimate' that service users are over 16 years of age.

Most NHS Patient Surveys generally exclude patients under the age of 16 from surveys. There was a risk therefore that callers under 16 might be included in these trust samples. Our suggestion for mitigating this problem was to ask a screening question at the beginning of each telephone call asking all participants to confirm that they are indeed over 16 years of age.

All other trusts were able to report year of birth information for callers and did not find this to be a cumbersome problem.

2.3.2 Call duration

In the AMPDS system there are often two calls, an initial call from the service user and then a call back from the clinician. This can occur in NHS Pathways as well as part of the triage process, though not as standard. The main point surrounding call duration is that all trusts must understand that it is the primary triage call for which we need to know the duration. This information should be

[1] Where 'caller' is the service user themselves even if not specifically the patient

stored in all trusts' CAD systems. Although CAD systems do vary, it appears that this information is a standard item to collect. However, two trusts (East Midlands and South East Coast) do not have a CAD system that typically collects this information. Consultation between the research team and these two ambulance trusts was conducted to determine whether or not they could devise a procedure for collecting call duration for the purposes of the national survey. Although ultimately it was not able to be included in the questionnaire, there were questions to assess some aspects of call timing, including how service users felt about the length of time they waited for a call back from the ambulance service.

2.3.3 Diagnosis codes and call outcome[1]

Whilst other areas of medicine apply standard diagnosis codes to each service user, this is not common practice in hear and treat ambulance services. There are no universal diagnosis codes or mechanisms for recording call outcome descriptions across the NHS Pathways and AMPDS systems. Such information would have been interesting, but it is not central to the purposes of this survey. It would be more useful to inquire about diagnosis and call outcome information in the survey itself.

2.3.4 Ethnicity

Ambulance trusts reported that they do not collect this information as part of the hear and treat process, and would therefore be unable to supply this as part of the sample. Collecting this demographic data could be done at the end of the interview via a standard question item.

2.3.5 Location of service user

Whilst ambulance trusts establish whether a service user is calling from a public place or not, they do not record this information in a standard way in either their operating systems and would be unable to provide this as sample data as a consequence.

2.3.6 Telephone numbers

As part of the sampling pilot, trusts were asked to submit a contact telephone number for each record, truncated to the first five digits. In doing this, the coordination centre would be able to estimate the sample quality for a national survey and the proportion of mobile numbers in a final national sample. Overall, the total pilot sample was 45% mobile numbers across all trusts, and the quality of the sample itself was good with very few numbers that appeared ineligible. At the sampling pilot stage trusts provided telephone numbers truncated to five digits, so it was only possible to judge whether a telephone number was eligible by checking that it began with a zero and valid area code.

2.3.7 Sampling exclusions

Trusts were asked to exclude from their sample any duplicate service user records, any known deceased service users or records that contained incomplete information for a telephone survey. Most trusts reported that less than 1% of their sample frame was excluded due to this. One trust

[1] In this context, outcome refers to 'outcome of the call' rather than a medical or diagnostic outcome, for example: 'service user given self-care advice'

was anomalous with 68% of their original sample eliminated. After consultation with this trust, however, it became clear that sampling was not conducted in accordance with the guidance, and that the rate of removal would have been significantly lower had sampling been as stipulated. A second trust removed 21% of their original sample, and they explained that this was due to their inability to record all third party names. This did not present a problem in the national survey, for this particular trust, as the sample size was large enough to mitigate against this.

The other data fields (listed again below) are available in both systems and could be provided in a standard fashion for a national survey.

1. Telephone number.
2. Gender.
3. Date of call.
4. Time of call.
5. Who made the call (i.e. patient or third party).

2.4 Sampling methodology

Each trust completed the sample pilot, and as mentioned above, this concluded that they could gather all the necessary information.

The principle concern regarding sampling was around how many cases each trust will deal with during the given sampling period. The sample pilot yielded huge variation in the numbers of service users recorded for the sample week. The sample week was the same for all trusts and ran from 00:00hrs on Monday, November 26th to 23:59hrs on Sunday, December 2nd, 2012 inclusive. During this period trusts were asked to collect a census of all hear and treat service users. Trusts were asked to exclude some cases before returning their sample files to the co-ordination centre, such as removing duplicated records, services users aged under 16 years old, any deceased services users and those with insufficient contact information for a telephone survey to be conducted. The mean number of eligible service users for this sample week was 462.8 with a standard deviation of 390.7 ranging from 55 to 1325 (not including the Isle of Wight which only had 24 cases). The discrepancies in reported service users were disproportional to variation in the population of areas covered by each trust. Whilst some of this could be accounted for in some trusts not abiding by the guidance properly and sampling cases outside of the G4[1] specification noted in the guidance, there were still some trusts with very few eligible patients – and in some cases a longer sampling period may be required.

After consultation it has become clear that some trusts have a greater ability to handle hear and treat callers than other trusts. It was suggested that some are more 'advanced' with hear and treat callers, both G3 and G4, and therefore provide telephone triage for patients who might have received an ambulance had they been in other trusts. There was no way of verifying this at an individual user level, but it is worth noting that some trusts may have an enhanced proclivity towards categorising users as hear and treat due to their specific resources and capacities.

[1] G4 refers to hear and treat calls where the clinical recommendation is that the service user requires a telephone assessment within 60 minutes of call connect. G3 refers to hear and treat calls where the clinical recommendation is that the service user requires a telephone assessment within 20 minutes of the call connect preferably on a live transfer basis. These definitions were devised by the Ambulance Directors of Clinical Care (DoCC) (now the National Ambulance Service Medical Directors' group (NASMeD)) and approved by the Emergency Call Prioritisation Advisory Group (ECPAG).

For the purposes of a national survey, the sampling period was one month which is in line with other NHS Patient Surveys in the national programme. For the purpose of the sampling pilot trusts were required to collect a census of G4 service users dealt with during a one week period. This was in part to reduce the burden on ambulance trusts and from suggestions that each ambulance trust would have a sufficiently large G4 population from which to draw a sample. As a result of the pilot, it has become apparent that each trust deals with a varying size population of G4 service users so for a national survey we decided to include G3 service users as well in order to gather a sufficiently large sample for each trust.

To minimise any sampling burden for trusts, we recommended that each trust should collect a *census* rather than a *sample* of G3 and G4 service users within a given sampling period. This information was provided to the coordination centre (subject to standard ethical and Section 251 approvals) and random samples were drawn for trusts with a sufficiently large sample frame.

The suggested sample size for each of the trusts drawing a random sample was 1000 service users. Based on an expected 40% response rate, this equates to 400 completed interviews for each trust. Based on these estimates the responding sample will be large enough to be statistically significant and allow comparability across the different ambulance trusts. It is considered unlikely that East Midlands would achieve 400 completed interviews, due to the smaller sample size, however it was felt it should still be possible to achieve a sufficient number to allow for comparability.

2.5 Feasibility of Questionnaire design

There were a few major challenges to designing a questionnaire to reflect the key areas of importance to hear and treat service users. The principal concern in design of the questionnaire related back to the differences between MPDS and NHS Pathways. Since service users of MPDS trusts generally receive a call back rather than be triaged during their original call, their route through the system is therefore distinctly different from someone receiving triage via NHS Pathways. This was not considered too much of a problem because each service users unique record number is linked to a certain trust so we can identify which system the service user experienced. The benefit of a telephone survey, is that the computer assisted telephone interview (CATI) could be programmed to route service users past non applicable questions based on their unique record number.

2.6 Feasibility Summary

Whilst it is necessary to bear in mind the one caveat around age and year of birth information, we concluded that confirmation that a service user is aged 16 years old and above is possible via a screening question at the beginning of each telephone interview. Year of birth information would be collected at the end of the interview as standard. Otherwise, the concerns with disparities in AMPDS and NHS Pathways and gathering uniform sample information only impact ‘wish list’ type data fields and do not compromise the overall viability of the survey. In terms of drawing a sample that will yield robust results, this should not be a challenge to any of the trusts given the suggested methodology. Finally, despite some hesitation around the differences between AMPDS and NHS Pathways, trusts were keen and willing to take part in this survey and valued the service user experience information it would provide.

3 Consultation with Trusts

3.1 Introduction

This chapter provides a briefing on the consultation with ambulance trusts to inform the development of a national 'hear and treat' ambulance service user experience survey carried out by the Co-ordination Centre, based at the Picker Institute Europe, on behalf of the Care Quality Commission (CQC). The aims of the consultation were to achieve the following:

- Determine the salient aspects of service user experience, from the perspective of the ambulance trusts
- Identify and understand what potential topics to focus our questionnaire

The consultation phase produced valuable information regarding important questionnaire areas and logistical considerations for running a national survey.

3.2 Consultation Findings

3.2.1 Questionnaire Topic Areas

The reason for identifying the most salient aspects of service user experience was to understand how to focus the questionnaire to make sure we gathered data on all relevant areas. We wanted to ensure that when service users completed a questionnaire they would have had the opportunity to evaluate the components of care that matter most to them. This then provides ambulance trusts and national agencies such as CQC, Department of Health and NHS England, with valuable data to identify whether service improvements are required.

Representatives from each of the ambulance trusts helped us identify the following as critical areas from which to base questionnaire items.

Dignity and respect was one of the main areas that stakeholders felt should be explored in the questionnaire. Questions about whether patients felt that staff treated them with dignity and respect are standard to questionnaires in the National Patient Survey Programme and stakeholders found it important they be extended to the 'hear and treat' survey as well.

Listening: Across services listening on behalf of staff is important to providing a positive service user experience. Considering many 'hear and treat' service users will only have contact with the service over the phone, appropriate listening skills were considered especially relevant.

Re-contact and service effectiveness: Many stakeholders were potentially concerned that 'hear and treat' service users were often having to re-contact the ambulance service after having undergone the 'hear and treat' process. Their general consensus was that there should be questionnaire items that address whether or not the advice given was clear, sufficient and

actionable and whether or not the service user had to re-contact the ambulance service more than once for the original problem.

Safety and confidence in staff: The safety of service users during their call was another major theme which stakeholders thought would be particularly important to service users. Considering the high-stress nature of ambulance services, trusts and inspectors agreed that it is critical to ensure that service users feel safe and confident in the call taker's ability to triage and treat them over the phone.

Time: Time both in terms of the time between placing a call and receiving a call back or being connected to the clinician's desk, and the duration of time the entire 'hear and treat' process takes was of major concern to stakeholders. They were keen that questions be asked about how service users felt about these times to assess whether they are acceptable. It was also considered important to establish how long service users felt they waited to speak to a clinician, if being called back.

Expectation vs. outcome: This is a particularly salient aspect of service user experience in 'hear and treat' services, as often service users phone 999 expecting to receive an ambulance response. Stakeholders wanted to make sure that the questionnaire investigated whether or not the 'hear and treat' service mets their expectations in terms of providing advice and care, and whether service users were satisfied with the outcome of the call, even if this did not match their prior expectations.

Questions: Stakeholders who were familiar with the NHS Pathways system were keen that questionnaire items address what service users felt about the series the questions asked to determine the need for an ambulance. Due to the relative infancy of NHS Pathways, stakeholders thought that service user data regarding the NHS Pathways procedure would be useful to evaluating how the system is working as a whole.

3.2.2 Logistics

Two logistical issues also required clarification during the consultation.

The primary concern was over NHS 111 calls. Those trusts that use the NHS Pathways system (North East Ambulance Service, West Midlands Ambulance Service, South East Coast Ambulance Service and South Western Ambulance Service) potentially deal with some NHS 111 calls as well as 999 calls. After consultation with a majority of the ambulance trusts for whom this is the case, it became clear that ambulance trusts typically only receive a NHS 111 call if an ambulance response is required. In the rare cases where a NHS 111 call is sent through to the 'hear and treat' desk at the ambulance trust, trust representatives report that it is very easy to identify where such calls originated from (i.e. where they placed as NHS 111 or 999), therefore making it possible to exclude NHS 111 calls from the sample and solely focus on 999 callers.

The second logistical issue arose over the difference between the NHS Pathways and AMPDS systems in terms of the service user information the trusts are able to collect. The primary difference, and the only one that held any significance to the viability of the survey, was whether or not each system to could collect age information of service users. After speaking with each trust about this, it became clear that while exact age information might not be available for every trust, an approximation will be available, including a confident estimate of whether a service user is over 16 years of age for ethical purposes.

3.3 Trust Consultation Conclusions

The discussion with ambulance trusts was an important element of the overall survey development work. It identified potential areas of importance for questionnaire topics, and provided clarification regarding how NHS 111 calls are dealt with. This information made it possible to take the next steps in designing a questionnaire as well as providing guidance to conduct the survey.

4 Consultation with Service Users

4.1 Focus groups

The Coordination Centre needed the views of service users to understand the most important elements of patient's experiences. This was essential for a new survey in particular.

Recruitment for these focus groups was particularly difficult however. Hear and treat service users form a very niche and unique group of service users. Therefore it would have been unproductive to recruit in standard ways with newspaper advertisements. Researchers needed to be certain they were indeed holding discussions with people who went through a particularly type of triage. The optimal approach was to recruit through an NHS ambulance trust's R&D office. This required strict ethical approval which was sought and received in collaboration with London Ambulance Service on 20 May, 2013. Unfortunately, however, this approach did not yield sufficient numbers of patients who had previously consented to take part in research.

Instead, the CQC and Coordination Centre opted to use an external recruitment consultancy, Oracle Fieldwork. Oracle was given a specification of what types of service users were required and an ideal demographical breakdown. Oracle was able to recruit enough people for focus groups in Birmingham and Manchester. The cities fall under trusts that use NHS Pathways and MPDS respectively, meaning researchers were able to gather input from service users in both triage systems. The following charts show the breakdown of service users for the two groups.

Birmingham Focus Group – June 18, 2013

Gender	Age	Contacted Ambulance via 999 service	Had telephone Triage from Ambulance Service	Reason for Calling 999
Female	40-49	Yes	Yes	Called for her mother
Male	20-29	Yes	Yes	Called for girlfriend
Female	30-39	Yes	Yes	Called for son
Female	20-29	Yes	Yes	Called for young person
Female	20-29	Yes	Yes	Called For friend

Male	60-69	Yes	Yes	Called For elderly mother
Male	30-39	Yes	Yes	Called for neighbour
Male	30-39	Yes	Yes	Called for man having a panic attack
Male	20-29	Yes	Yes	Called for children
Male	30-39	Yes	Yes	Called for injured child

Manchester Focus Group – July 10, 2013

Gender	Age	Contacted Ambulance via 999 service	Had telephone Triage from Ambulance Service	Reason for calling 999
Male	50-59	Yes	yes	Mother
Male	40-49	Yes	yes	Friend
Male	40-49	Yes	yes	Wife
Female	40-49	Yes	yes	Husband
Female	40-49	Yes	yes	Resident
Female	50-59	Yes	yes	Elderly tenant
Female	30-39	Yes	yes	Husband
Female	20-29	Yes	yes	Mother
Female	30-39	Yes	yes	Child
Male	50-59	Yes	yes	Self

4.1.1 Birmingham

Two focus groups were conducted with hear and treat service users; a summary of themes from these groups follows.

Motivations for calling 999: The first focus group, held in Birmingham, covered motivations for calling 999, urgency of call, nature of the telephone advice given by the ambulance service and any other input the service users had. Concerning motivations for calling 999, many participants described situations in which they felt their case was an emergency, and they did not want to pursue other care options and risk not treating the problem quickly enough. Some said their incidents happed out of hours, and the GP would not have been available. The general consensus, for unknown reasons, was that a lot of emergencies tended to happen at night or on weekends. In Birmingham participants cited the Badger Clinic (Birmingham and District General Practitioner Emergency Rooms) as a potential out of hours alternative to 999 as well as NHS Direct, but considered their cases too urgent for these services. Some said that in hindsight they would not have dialled 999, but at the time they felt it an emergency.

"I didn't try any other services and went straight for ambulance as it was a head injury for a child with vomiting, so thought it was serious so went straight for '999'; wasn't sure what to do so just called the ambulance."

"Thought it was a heart attack so was panicking and called '999'. It was for an older person so didn't really know what to do."

One woman had been advised by the hospital to call 999 if her problem relapsed. This left her with the feeling that she would receive an ambulance if she dialled 999, but she received hear and treat services instead.

When asked about NHS Direct as an alternative to 999, participants explained that the process was too long and required answering too many questions.

"[The} Ambulance service asks questions that are more relevant to why you're calling and to what you're calling them about. Turns out that you end up calling the ambulance anyway."

One other important message that emerged in this section was that some people were required by employment regulations to call 999 in response to certain incidents regardless of whether they thought an ambulance is required. One woman described that the care home in which she worked mandated all employees to dial 999 if an elderly patient falls in the home. Had this rule not been in place she said that she would not have called 999 in this situation.

Urgency of call and Need for Ambulance: During this component of the focus group participants discussed whether they thought their situation was urgent enough to require an ambulance. This discussion elicited a diversity of findings. The participant who was required to dial 999 to comply with the practice guidelines at the care home where she worked said that she did not feel her case necessitated an ambulance, and would and did not want to transport the elderly man. Another participant echoed this sentiment:

"*Glad to have advice over the phone. I was hoping it wasn't too bad when I called. I was upset and didn't want it to be serious, I just wanted to get some advice."*

However, this feeling was not universal. Some people only called 999 because they thought their situation warranted an ambulance response. Some found the consultation too lengthy, which they felt was counterproductive to treatment.

"I was discouraged. I thought it was serious. The consultation took a long time. It would be quicker to put the person in the car and drive them to hospital yourself."

Overall the feedback on need for an ambulance was mixed: some appreciated receiving advice only, where as others found it the wrong course of treatment, and, at times, a disrespectful "fobbing off." What also arose from this conversation was that service users were unclear about what criteria deem an ambulance necessary or what a patient's needs must be to receive one.

"Each situation or scenario is different really. Such as the time of day you call, who you end up speaking to, how busy they are and sometimes it's just quicker for you to take the person to hospital yourself if that's what's needed."

"I don't get why people who call and don't need an ambulance get one, and when you need an ambulance you don't."

Nature of the advice given: The conversation moved to the actual advice given to the service users. Many participants had positive feedback about the nature of the advice. They explained how important it was to them that the telephone advisor be reassuring, as many of them called in a panicked state.

> *"Overall they were friendly and they calmed me down. Very re-assuring as I was calling about a child and I didn't know what to do. They ran through what was wrong, the danger signals to look out for, ran through the drill and they were very good. Kept asking 'are you ok?' Very detailed and very re-assuring."*

> ***"**Generally, you don't want to see people carted off to hospital especially elderly people as it's not good for them. If you can get advice over the phone it's very good. I've been very lucky as the people I've spoken to have been very helpful"*

A few people repeated this sentiment but noted that while the advice was good, they would have preferred to get an ambulance.

A second important finding was the attention many people paid to the questioning involved in the telephone advice process. A few people described how the number of questions seemed daunting, and other that the question set seemed ridged and irrelevant to their condition. This did not necessarily detract from the advice, but it impacted their overall experience. Also, some service users felt unnerved by the questions because they did not always know how to respond or what would happen if they responded incorrectly.

> *"When you've called 999 and you get put through to the ambulance person, you feel like they are just ticking things off a list and you don't necessarily get that with a clinician or doctor."*

> *"I wasn't told about what was happening throughout the questioning."*
> *"You want to be treated with compassion, respect, dealt with quickly and properly. I felt like the person I spoke to just didn't care. I feel it varies with age*."

> *"Confidence in the advice depends on the person who is giving it and the person who calls. Sometimes the questions aren't always relevant and you need the person to understand that."*

A few service users who spoke to more than one person at the ambulance service expressed that clinicians gave more useful advice than call takers. The general feeling was that clinicians did not follow a script in the same way as the call takers did. Service users did not mind that the call takers had to ask some questions, but they preferred the way the clinicians asked questions based on their concerns.

> *"With the initial call you always feel 'am I going to get anywhere with this?' and it feels so rushed. They're so complacent and a real lack of engagement with you. It feels like they just don't want to be there when you talk to them."*

> *"The call backs are great. Very helpful. They move to more relevant questions right away and they are really friendly when you speak to them. They are very accommodating of what you're going through and just brilliant."*

The resounding points were that call handlers and advisors should be reassuring and attentive throughout the call and avoid ridged questions as much as possible.

Next steps of the care process: The discussion concluded with a brief conversation about the next steps of the care process and whether these were fully explained by the ambulance service. Researchers enquired about whether the call takers and telephone advisors explained what to do in the event that conditions worsened. Most service users said that this was explained to them. Mostly people were told to dial 999 if things got worse or to contact their GP immediately. Participants were generally satisfied with this part of the call, but saw it as a very important component nevertheless.

4.1.2 Manchester

The second focus group, held in Manchester, attempted to confirm findings from the first focus group, it also probed new topics such as alternative options to dialling 999, service users' expectations and feelings on the transfer of service user details for research purposes.

Alternative services: During the second focus group, the intention was to establish what service users' reasons were for dialling 999 rather than the alternative sources of care like NHS Direct or A&E. What we found was that service users not only perceived their cases as emergencies and dialled 999 out of panic, many of them had considered the alternatives, but thought them too slow, or unsafe for the particular situation, one woman was also advised by the police to call 999.

> "*I called the police as they have to do a welfare check when young people in care are involved. The police told me to call the ambulance as they didn't know what substance they had taken.*
>
> *"I took her to A&E instead as they didn't send an ambulance…It's shocking there. We're not snobs or anything but it's ridiculous. It's quicker if you just call an ambulance."*
>
> *"With young people you can't put yourself at risk. I wouldn't take them in the car as I don't "know what's wrong with them or what they've taken. It's too risky. Too unpredictable"*

Hear and Treat process: This part of the focus group went through the technical process of hear and treat to help researchers get a better understanding of exactly what people experience on the phone. Most respondents referred to the call taker or telephone advisor as being reassuring or calming while also asking questions to understand the problem.

> *"They were really calm on the phone. Really relaxed. They asked me all the questions I presume they're supposed to ask. It was re-assuring. They stay on the phone to you."*

When asked more specifically about the advice they were given over the phone, four things emerged as particularly important to service users: the call taker or telephone advisor's medical knowledge, the appropriateness of questions, the clarity of instructions and appropriateness of personal involvement.

> *"The person I spoke to, I didn't think was medically trained. They didn't tell me who they were or their job title. I didn't get their name."*
>
> *"They just read off a list of questions to me. It was just triage."*
>
> *"When my husband fainted I was panicking. He was vomiting. They were really good. Very clear instructions. I felt involved in the process throughout. They were professional and respectful."*

Explaining next stages: One things that was covered in this section that was different from the first focus group was whether or not the ambulance service arranged appointments for service users at other services or if they were required to do this on their own. Some service users agreed with the decision to be referred on to another service, but were troubled by the lack of help in arranging what to do next.

> *"Took my wife but '999' told us to go to A&E but they didn't know we were coming. With my Mum they were ready for us."*

> *"Not really necessary. They just hang up the phone if you don't have an ambulance. Done."*

Expectations: Most people in this group expressed that they did expect an ambulance, and that it was particularly important to have it explained why they would not be receiving one. Some people also demonstrated how little is known about ambulance dispatching.

> *"I kind of thought that it would come up on their system that I've never called '999' so it's serious. Not a prank. They could see that 'hey, this guy's not called before so it must be serious'."*

> *"They keep you calm but you feel like you're kept on line for delay tactics as you're not going to get an ambulance quickly."*

Overall: The final part of the focus group surrounded what individual service users found to be the most important parts of their experience overall. One of the first issues to surface was communication- communication between the ambulance service and the service users, between the ambulance service and the hospitals, and between staff at the ambulance service themselves.

> *"There wasn't much communication between who we spoke to on the phone and the ambulance crew when they arrived. They crew didn't know half the details. They'd not been told. Not good communication."*

> *"No communication between drivers who turn up and the actual crews."*

> *"Better communication between hospitals. It needs to be much better."*

Another salient item was questioning. Service users expressed that they felt ill-equipped to answer some of the questions, especially those who called on behalf of non-family members. The discussion over questioning also fed in to some concerns over time. A few service users felt the amount of questions may have been excessive and the total time could have been reduced.

> *"You question yourself when they ask you something. Your head is in a million places. You can't think."*

> *"You can't always answer the questions. You just don't have the information like 'how high has she fallen from?'"*

> *"It annoyed me the length of time it took."*

The overall sentiment on hear and treat varied; it generally took the tone of a sincere thanks for a useful service or a call for more opportunity to receive an ambulance.

> *"I'd like to say thank you. For their advice. Their re-assurance."*

"I wish they'd taken a gamble and sent an ambulance. [Now] My wife can't even put on her bra."

Transfer of contact details: The final point was a technical one about transfer of contact details from the ambulance service for the purposes of research and service improvement without service users' consent. Service users had no reservations about this and were in fact quite encouraging of the ambulance service doing more research with service users.

"I'd be fine with that. It's about giving feedback."

"Yeah, it's like that complaints versus compliment thing. Otherwise it's unacknowledged if it's good or bad. They need to know what their service is like."

"How else would you tell them? It's not like you can call '999' again and say 'I called you last week and you didn't send an ambulance and I'm not very happy about that.'"

Ultimately the focus groups succeeded in obtaining information regarding what is most important to service users and first-hand accounts of hear and treat experiences. These testimonies were invaluable to the development process and they formed the cornerstone of questionnaire development.

4.2 Live 999 Calls

The Coordination Centre also collaborated with two ambulance trusts to listen in to live 999 calls. This helped inform the development of the questionnaire and ensure that researchers were as familiar with the hear and treat process as they could be.

The two trusts who invited researchers to listen to live 999 calls were North East Ambulance Service and London Ambulance service, which use NHS Pathways and AMPDS respectively. The sessions at both trusts included an overview of their triage system from patient experience leads followed by one-on-one time with an active call taker. Researchers were given a headset which allowed them to listen into the 999 calls while the call taker dealt with them. The experiences at both trusts provided first hand insight into the role of the call taker and the typical nature of a hear and treat call. It also helped researchers to understand the protocol that call handlers follow that is supplementary to that of the triage system (NHS Pathways or AMPDS) which could also impact experience.

5 Questionnaire Design

The first stage of questionnaire design involved drafting a rough questionnaire based on the most salient topics that arose in the focus groups and consultation. Questions were drafted using example phrasing from well-tested questions in other National Survey Programmer questionnaires and adhered to cannons of best practice in questionnaire design.

5.1 Cognitive Interviewing

At three different stages during the drafting process, the questionnaire was tested with hear and treat service users through cognitive interviewing. This involved trained researchers from the Coordination Centre and CQC administering the survey to service users who would fit the sampling criteria for the national survey. This was in order to make sure service users understood the questions in the way they were intended. These interviews were conducted face to face with the interviewer reading the questions to the participant as the telephone interviewer would do during the national survey.

Three rounds of 12 interviews were conducted (on two occasions one interviewee did not attend). The first was based in Birmingham, the second in Manchester and the third included interviews in both Birmingham and Manchester. Interviewing took place between July and early September, 2013. Service users were recruited using an external recruitment agency Oracle Fieldwork. Participants were recruited based on a series of criteria: receipt of hear and treat ambulance services after calling 999, aged over 16 years, nature of their 999 call was not concerning pregnancy, mental health, domestic dispute or any otherwise sensitive issue. Participants received a £30 incentive for participating. Please refer to appendix one for a summary of how the questionnaire transformed throughout the cognitive testing process.

Gender	Age Range
23 Female	25 – 53 years
11 Male	33 – 65 years
34 Total	25 – 65 years

Intro to Calling 999: This section was not included in the first round of testing and was added for round two as a way of accounting for the differences between MPDS and NHS Pathways. It was added to establish who spoke to more than one person, so that they could be routed on to the second section of the survey about the second person, or telephone advisor in MPDS. The dispatcher question in this section also helped ensure that service users would not count the dispatcher as someone they spoke to at the ambulance service.

Reasons for calling 999: The first question in this section asks for whom the service used called 999. This question tested well in all round and remained the same. Service users said that they thought the distinction between calling about another adult or another child was important because it changes the nature of the circumstance. The next question about why service users dialled 999 underwent some changes between the first and second round after a few service users were inclined to tell their personal story rather than adhere to the response options.

First Person: This section was renamed from ‘Call taker’ to ‘First Person’ during the cognitive interviewing process to help people understand to whom the questions were referring. In the beginning it was called the call taker section, however people did not always recognize the first person they spoke to as the ‘call taker.’ Seeing as information about which trust the service user is affiliated with will be recorded, and that the Coordination Centre is aware of the triage systems each trust uses, it will be possible to know whether the first person is a call taker or a telephone advisor without specifically asking.

The content of this section focuses on the experience with the ‘first person,’ and did not require any substantial changes throughout the interviewing process. In response to the finding from the focus

groups and consultation phase, the questionnaire items focus on the nature of questioning, reassurance and personal involvement.

In terms of questions that the first person asked, the questionnaire items around relevancy tested well. The item regarding question rigidity was originally worded to ask service users if they had enough information to answer the questions. This tested poorly initially, as people did not understand whether the information was meant to come from the ambulance service or their own knowledge of the situation. It was changed just to ask people if they could answer the questions asked. The second version tested much better.

A second change that was made to this section in the last round of interviewing was a question to probe whether service users felt the first person was understanding them. Participants in the focus groups had expressed concerns about the call takers not sufficiently understanding the situation, so it was necessary to inquire about it. The question tested well with service users.

Finally, some interviewees felt that the questionnaire was too repetitive, which made them lose interest towards the end. To rectify this, the questions about referrals were removed from the 'first person' section and only covered at the end. This tested better and people did not feel as though they were answering the same question twice.

Second Person: This section required slightly more changing than the first person section.

The first drafts of the questionnaire had significantly more items in this section than the final draft. This was mainly because the first drafts included a series of questions about referrals in this section. The aim was to understand at which point in the hear and treat process the service user was referred on to a different service and what they thought of this referral. Ultimately this resulted in too many questions, which appeared very similar in content. A decision was made to only ask about referrals at the outcome stage of the call, so that service users do not have to answer two rounds of referral questions.

One question that was originally included in the second person section was one inquiring about being able to follow the advice given by the second person. Similar to the referral questions, this is now only covered in the outcome section. This made more sense to service users, and they appreciated not having to answer questions about following advice twice.

Another change was to the question about how long the second call took. Originally this was left open ended. After the first cognitive testing, this question was removed from the survey, as it was difficult for the service users to recall and call duration will be included in sampling information.

Other than these questions, the rest of the 'second person' section remained largely the same. The questions on whether or not the second person was knowledgeable, respectful, listening and so on tested well throughout the entire process. Similarly, the questions about whether people spoke to a second person and whether or not people minded repeating their information to the second person tested well consistently.

Outcome of call: The outcome of call section went through some restructuring in response to the testing. For the question which specifically asks what outcome occurred, participants found it difficult to slot their outcome into one of the response options. Furthermore, ambulance trusts had cited preventing re-contact as particularly important; subsequently questionnaire items were designed to assess if and why service users re-contacted the ambulance service. Similarly questionnaire items about the appropriateness of references.

Questions about referrals at first tested poorly because they were covered in two portions of the questionnaire, and some people understood a call back from the ambulance service to be a

referral. In later versions when referrals were only covered in the outcome section, and a limited response set was derived to capture the various referrals, the questions were understood much better.

The outcome section also evolved through testing to encompass overall questions which had previously been spread out through the first and second person sections, but were criticized for being too repetitive.

The overall questions about respect and kindness tested well and service users thought there was a need to inquire about both. This confirmed what we found in the focus groups where participants spoke about these two things being distinctly important.

The outcome questions remained the same in content, but were changed in terms of order and routing. In the final questionnaire, the outcomes each had a variety of routed questions following them that pertained to that specific outcome. This eliminated the need for repeat or irrelevant questions which bothered people during cognitive testing. Heavy routing was possible because of the nature of CATI telephone surveys in which the routing is pre-programmed into the software.

5.2 Questionnaire Drafting

In addition to the cognitive interviews, the questionnaire was edited based on trust and stakeholder input. A draft of the questionnaire was sent to all NASPEG representatives, and trusts were given time to raise issues or make suggestions. This process did not result in any major changes to the questionnaire however.

6 Procurement

One unique development requirement of this survey was the need to procure a fieldwork agent to conduct the telephone interviews. The Coordination Centre sent out an invitation to tender for the work to five organisations and all five responded with bids. The Coordination Centre reviewed the bids with a standard grading matrix covering a number of knowledge of the NHS/ health sector/ ambulance trusts, skill and experience, ability to do the work, approach to the work and cost.

The three agencies that scored the highest on this matrix were invited to interview with the Coordination Centre and CQC. The interview provided a chance for the three agencies to elaborate on their proposals and highlight any unique features of their approach to the project. It also allowed the Coordination Centre and CQC an opportunity to ask the agencies questions specific to the National Ambulance Survey.

Following the interview process, TNS-BMRB was selected to carry out the work.

7 Ethical Approval & S251

The development of the National Ambulance Survey required two ethics applications (one of which was for focus groups as described in an earlier chapter, two substantial amendments) and one application for Section 251 approval.

7.1 Ethics Application

This section focuses on the Ethics Application for the National Ambulance Survey rather than the application to conduct focus groups.. The Coordination Centre was required to apply for a proportionate ethics review detailing the ethical considerations for the survey, namely asking service users about their experience of a possibly sensitive issue and contacting service users via personal telephone numbers. Regarding the transfer of patient identifiable data, this was covered in the Section 251 approval.

The application was submitted to the North of Scotland REC and received provisional opinion on 3 June 2013 under the following conditions: that the Coordination Centre submit final documentation of the final Section 251 approval and provide a peer review of the research protocol from outside the research team.

The Coordination Centre met both of these conditions and received favourable approval on 8 July 2013.

7.2 Section 251

The Coordination Centre and CQC applied for Section 251 approval for the transfer of patient identifiable data from trusts to the Coordination Centre and from the Coordination Centre to the fieldwork agency. The survey was successfully awarded Section 251 Approval for the transfer of the required sampling information, and patient contact details, from each ambulance trust to the approved contractor (TNS-BMRB).

8 Pre-Survey Publicity Materials

The pre-survey publicity material for this survey was designed to reach as many hear and treat ambulance service users as possible. Given that hear and treat callers do not typically have any contact with the ambulance trust prior to the time the call, designing a publication method that was likely to be seen by this group was difficult.

The media decided upon was a website posting and local press release from each ambulance trust. The text for both the website and the press release were drafted by the Coordination Centre and agreed with the trusts. They were all sent the material and instructed to post it and submit it to

newspapers in November 2013. The text explained that the survey would not be running until February, but that the callers involved would be from December. The intent was for area residents to see the publicity and be made aware of the survey in the event that they do receive hear and treat services in December and would like to opt out or pose general questions. Display of this information by ambulance trusts, on their websites, and through the release of press articles was an additional requirement of the survey's Section 251 Approval.

9 Conclusion

The survey was administered between February and March, 2014. The survey achieved an adjusted response rate of 55%[1]. It provided new insight into how service users experience the hear and treat system. The final results were published on the Care Quality commission website here.

Appendix 1- Questionnaire Evolution

Table: Question Changes

Phase 1	Phase 2	Phase 3
	Dispatch Did an operator ask which emergency service you required? - Yes - No	**Dispatch** Did an operator ask which emergency service you required? - Yes - No
	NumberAmb How many people in total did you speak to at the ambulance service? Remember, this does not include the dispatcher who sent your call through to the ambulance service. - 1 - 2 - More than 2	**NumberAmb** How many people in total did you speak to at the ambulance service? Remember, this does not include the operator who put your call through to the ambulance service. - 1 - 2 - More than 2 - Not sure/ can't remember
Patient_TP Did you call '999' for yourself? - Yes - No, I called on behalf of another adult - No, I called on behalf of a child	**Patient_TP** Did you call '999' for yourself? - Yes - No, I called on behalf of another adult - No, I called on behalf of a child	**Patient_TP** Did you call '999' for yourself? - Yes - No, I called on behalf of another adult - No, I called on behalf of a child
Reason	**Reason**	**Reason**

[1] Overall, 45% of the original sample of 9,614 callers were unable to be contacted, for reasons such as telephone numbers not being in use or those answering the phone stating that they had not dialled '999' recently. The adjusted response rate was derived based on the percentage of those contacted who responded to the survey. This means that people who did not answer, had an unattainable number, moved were unavailable during fieldwork, were deceased or were otherwise unable to be contacted were excluded from the response rate. Please see the National Tables document at http://www.cqc.org.uk/content/ambulance-survey-%E2%80%98hear-and-treat%E2%80%99-callers-201314 for a full breakdown.

Why did you decide to call '999'? - A GP at my local surgery advised me to - An out of hours GP advised me to - NHS Direct/ NHS 111 advised me to - Some other health professional advised me to - Somebody else (eg: friend, relative) advised me to - I decided myself to call - Other reason	Why did you decide to call 999? - Not aware of any other services to call as GP was closed - Ambulance service told me to call 999 if became ill again with the same problemAnother health service/ professional advised me to call 999 - It seemed like an emergency - Other	Why did you decide to call 999? (INTERVIEWER: What else?) - My GP surgery was closed - Another health service/ professional had previously advised me to call 999 - The ambulance service had previously told me to call about this - It seemed like an emergency - I was unable to go anywhere as I had no transport available - I didn't know who else to call - The patient asked me to call - Other
Contact Did you contact another service or organisation for the same condition before you called '999'? - Yes - No	**Advise** Who advised you to call '999'? - A GP at my local doctor's surgery - A doctor at an out of hours service - NHS Direct/ NHS 111 - Some other health professional -Other service	**Advise** Who advised you to call '999'? - My local doctor's surgery - An out of hours GP service - NHS Direct/ NHS 111 - A walk in centre - A hospital or hospital department - Another health professional or service
SvceContact Which service(s) or organisation(s) did you contact before you called '999'? (MULTICODE) - GP out of hours service - GP at your local surgery - NHS Direct/ NHS 111 - Walk in centre or minor injuries unit - Urgent care - Community based care - Some other health professional - Other service/ organisation		
SvceTime How long before you called '999' did you contact [NAME OF SERVICE CONTACTED]? - 1- 30 minutes - 31- 60 minutes - More than 1 hour but no more than 2 hours - More than 2 hours but no more than 4 hours - More than 4 hours	**SvceTime** - How long before you called '999' did you contact [NAME OF SERVICE CONTACTED]? - 1- 30 minutes - 31- 60 minutes - More than 1 hour but no more than 2 hours - More than 2 hours but no more than 4 hours - More than 4 hours	**SvceTime** How long before you called '999' did you contact [NAME OF SERVICE CONTACTED]? - 0 -15 minutes - More than 15 minutes but less than an hour - More than 1 hour but no more than 4 hours - More than 4 hours but no more than 24 hours - Between 1 day and 1 week - More than 1 week
Consider Did you consider making contact with another service or organisation? - Yes - No		
ReasonNoCont		

What was the main reason you decided not to contact another service or organisation?		
		NoPersCheck At the start of the survey, you said you spoke to [1/2 person/people] not including the operator who put you through to the ambulance service. Is that correct? - Yes - No
ListenCT Did the call taker listen to all your details carefully? - Yes, completely - Yes, to some extent - No	**ListenCT** Did the call taker (the first person you spoke to at the ambulance service) listento you carefully? - Yes, completely - Yes, to some extent - No	**ListenCT** Did the [first] person you spoke to at the ambulance service listen to what you had to say? - Yes, completely - Yes, to some extent - No
		QuestionsCT Did you want to ask the [first] person you spoke to any questions? - Yes - No - Not sure/ can't remember
		OpportunityCT Did you have the opportunity to ask these questions? - Yes - No - Not sure/ can't remember
UndstndCT When you had important questions to ask the call taker, did you get answers you could understand? - Yes, completely - Yes, to some extent - No - Not sure/ can't remember	**UndstndCT** When you had important questions to ask the call taker, did you get answers you could understand? - Yes, completely - Yes, to some extent - No - Not sure/ can't remember I had no important questions to ask I didn't have the opportunity to ask questions?	**UndstndCT** Did you get answers you could understand? - Yes, completely - Yes, to some extent - No, the answers were not easy to understand - I did not get any answers - Not sure/ can't remember
InvolvCT Were you involved as much as you wanted to be in decisions about your care? - Yes, definitely - Yes, to some extent - No - Don't know / can't remember		
FearsCT Did you have the opportunity to discuss any fears or anxieties with the call taker? - Yes, definitely - Yes, but I did not want to discuss these - No, but I wanted to discuss these - No, but I did not want to discuss these - I did not have anxieties or fears	**FearsCT** Did you have the opportunity to discuss your fears or anxieties with the first person you spoke with? - Yes and I did thisI feel I could have done but didn't want to / I was given the opportunity but didn't want to - No - I did not have anxieties or fears	**FearsCT** Did you have the opportunity to discuss any fears or anxieties with the [first] person you spoke with? - Yes and I did this - I could have done but didn't want to - No - I did not have fears or anxieties

InfoCT How much information did the caller taker give you about what they thought was wrong with you? - Too much - The right amount - Not enough - Don't know/ can't remember		
ConfCT Did you have confidence in the call taker? - Yes, definitely - Yes, to some extent - No	**ConfCT** Did you have confidence in the first person you spoke with? - Yes, definitely - Yes, to some extent - No	**ConfCT** Did you have confidence in the [first] person you spoke with? - Yes, definitely - Yes, to some extent - No
ReassureCT Was the call taker reassuring? - Yes, definitely - Yes, to some extent - No - Don't know/ can't remember	**ReassureCT** Was the first person you spoke with reassuring? - Yes, definitely - Yes, to some extent - No - Don't know/ can't remember	**ReassureCT** Was the [first] person you spoke with reassuring? - Yes, definitely - Yes, to some extent - No - Don't know/ can't remember
DignityCT Were you treated with dignity and respect by the call taker? - Yes, completely - Yes, to some extent - No	**DignityCT** Were you treated with dignity and respect by the first person you spoke with? - Yes, completely - Yes, to some extent - No	**DignityCT** Were you treated with dignity and respect by the [first] person you spoke with? - Yes, completely - Yes, to some extent - No
ApprQnsCT In your opinion do you think the call taker asked an appropriate number of questions? - Yes - No, there were too many - No, there were not enough - Don't know/ not sure	**ApprQnsCT** In your opinion do you think the first person asked an appropriate number of questions? - Yes - No, there were too many - No, there were not enough - Don't know/ not sure	**ApprQnsCT** In your opinion do you think the [first] person asked an appropriate number of questions? - Yes - No, there were too many - No, there were not enough - Don't know/ can't remember
QnRelevant In your opinion did you feel that the questions the call taker asked were relevant to your situation? - Yes, definitely - Yes, to some extent - No - Don't know / can't remember	**QnRelevant** Were the questions the call taker/ first person asked relevant to your situation? - Yes, definitely - Yes, to some extent - No - Don't know / can't remember	**QnRelevant** Did you feel that the questions the [first] person asked were relevant to your situation? - Yes, definitely - Yes, to some extent - No - Don't know / can't remember
QnRigid Did you feel that you had enough information about the reason for calling to answer the questions the call taker asked? - Yes, definitely - Yes, to some extent - No - I was calling about myself - Don't know / can't remember	**QnRigid** Could you answer the questions the first person asked you? - Yes, definitely - Yes, to some extent - No - Don't know / can't remember	**QnRigid** Could you answer the questions the [first] person asked you? - Yes, definitely - Yes, to some extent - No - Don't know / can't remember
		UnderstandingCT Did you feel that the [first] person you spoke to understood what you were telling them? - Yes, definitely - Yes, to some extent - No

		- Not sure/ can't remember
ExplainCT Did the call taker explain what would happen next? - Yes, completely - Yes, to some extent - No - Don't know / can't remember	**ExplainCT** Did the first person you spoke to explain what the ambulance service would do next ? - Yes, completely - Yes, to some extent - No - Don't know / can't remember	**Explain** Did the first person explain the reason for this advice? - Yes, definitely - Yes, to some extent - No - I did not want or need this explanation
LikedExplainCT Would you have liked them to explain what would happen next? - Yes - No - Don't know/ not sure	**LikedExplainCT** Would you have liked them to explain what would happen next? - Yes - No - Don't know/ not sure	
InfoGivenCT Were you given instructions by the call taker on what to do if the situation changed? - Yes - No - Don't know/ can't remember	**InfoGivenCT** Did the first person tell you what to do if the situation changed? - Yes - No - Don't know/ can't remember	**InfoGivenCT** Did the first person tell you what to do if the situation changed? - Yes - No - Don't know/ can't remember
InfoFollowCT Were you able to follow the instructions given? - Yes, definitely - Yes, to some extent - No - Not sure/ can't remember	**InfoFollowCT** Were you able to follow the instructions given? - Yes, definitely - Yes, to some extent - No - Not sure/ can't remember	**InfoFollowCT** Were you able to understand the instructions given? - Yes, definitely - Yes, to some extent - No - Not sure/ can't remember - I was not given any instructions
InfoNFollowCT Why were you unable to follow the instructions?	**InfoNFollowCT** Why were you unable to follow the instructions?	
CallRefCT Thinking about your conversation with the call taker, were you referred to speak to another service at any point. - Yes - No	**CallRefCT** Thinking about your conversation with the first person, were you referred to speak to another service at any point . - Yes - No	
ExplainRefCT Did the call taker explain why your call was being referred? - Yes, completely - Yes, to some extent - No - Don't know / can't remember	**ExplainRefCT** Did the first person explain why your call was being referred? - Yes, completely - Yes, to some extent - No - Don't know / can't remember	
WhichRefCT Which service was your call referred to? - A GP at my local surgery - An out of hours GP - Accident & emergency services - Community care services - Some other health professional	**WhichRefCT** Which service was your call referred to? - A GP at my local doctor's surgery - An out of hours GP or other out of hours service - Hospital including accident & emergency services - Community care services (eg: district nurse) - Some other health professional - Other - Some other health professional - Other	

ContactRefCT Did you have to make contact with this service yourself? - Yes - No, the call taker did this for me - Don't know / can't remember	**ContactRefCT** Did you have to make contact with this service yourself? - Yes - No, the call taker did this for me - Don't know / can't remember	
ApproRefCT Did you agree at the time with the decision to refer you? - Yes, definitely - Yes, to some extent - No - Don't know / can't remember	**ApproRefCT** Did you agree at the time with the decision to refer you? - Yes, definitely - Yes, to some extent - No - Don't know / can't remember	
RefQualityCT How would you rate the quality of care you received from the service you were referred to? - Excellent - Very good - Good - Fair - Poor - Very poor - Not sure/ can't remember	**RefQualityCT** How would you rate the quality of care you received from the service you were referred to? - Excellent - Very good - Good - Fair - Poor - Very poor - Not sure/ can't remember	
SpokeTA Did you speak to a telephone advisor? - Yes - No - Not sure/ can't remember	**CallBackTA** Did you speak to a telephone advisor? - Yes, they called back after the original call - No, I was put through to them during my initial call - No	**CallBackTA** Did you speak to a telephone advisor? - Yes, they called back after the original call - No, I was put through to them during my initial call - No
AwareCallBackTA Was it explained what would happen next after this call ended? - Yes, I was told - No, I was not told and I would have liked to know - No, I was not told and I did not mind - Don't know / can't remember	**AwareCallBackTA** Was it explained what would happen next after this call ended? - Yes, I was told - No, I was not told and I would have liked to know - No, I was not told and I did not mind - Don't know / can't remember	**AwareCallBackTA** Were you told you would receive a call back? - Yes, I was told - No, I was not told and I would have liked to know - No, I was not told and I did not mind - Don't know / can't remember
TimeCallBackTA After you finished your initial 999 call, how long did you have to wait before you received a call back from the telephone advisor?	**TimeCallBackTA** After you finished your initial 999 call, how long did you have to wait before you received a call back from the second person ?	**WaitCallBackTA** Were you told what to do while you waited for the call back? - Yes, I was told - No, I was not told and I would have liked to know - No, I was not told and I did not mind - Don't know / can't remember
		ExplainTimeCallBack Were you told when you would be called back? - Yes, I was told - No, I was not told and I would have liked to know - No, I was not told and I did not mind - Don't know / can't remember
		TimeCallBackTA

		After you finished your initial 999 call, how long did you have to wait before you received a call back from the second person? - 0-20 minutes - 21-60 minutes - More than an hour but less than 2 hours - More than 2 hours but less than four hours - More than 4 hours
FeelCallBackTA How do you feel about the length of time you waited before someone called you back? - It was sooner than I expected - It was as soon as I thought was necessary - It should have been a bit sooner - It should have been a lot sooner - Not sure/ can't remember	**FeelCallBackTA** How do you feel about the length of time you waited before someone called you back? - It was sooner than I expected - It was as soon as I thought was necessary - It should have been a bit sooner - It should have been a lot sooner - Not sure/ can't remember	**FeelCallBackTA** How do you feel about the length of time you waited before someone called you back? - It was sooner than I expected - It was as soon as I thought was necessary - It should have been a bit sooner - It should have been a lot sooner - Not sure/ can't remember
OverallTimeTA Overall, how long did your call with the telephone advisor last?	**OverallTimeTA** Overall, how long did your call with the second person last?	
		ExplainTA Did the ambulance service explain why an ambulance would not be sent on this occasion? - Yes, completely - Yes, to some extent - No - Don't know / can't remember
		AgreeTA Did you agree with the decision not to send an ambulance? - Yes, completely - Yes, to some extent - No
	KnowledgeTA Did you have to repeat your reason for calling '999' to the second person you spoke to? - Yes, definitely - Yes, to some extent - No - Don't know / can't remember	**KnowledgeTA** Did you need to repeat your reason for calling '999' to the second person you spoke to? - Yes, definitely - Yes, to some extent - No - Don't know / can't remember
		MindRepeatTA Did you mind having to repeat yourself? - Yes, definitely - Yes, to some extent - No
ListenTA Did the telephone advisor listen to what you had to say? - Yes, completely - Yes, to some extent - No - Don't know / can't remember	**ListenTA** Did the second person listen to what you had to say? - Yes, completely - Yes, to some extent - No - Don't know / can't remember	**ListenTA** Did the second person you spoke to at the ambulance service listen to what you had to say? - Yes, completely - Yes, to some extent - No - Don't know / can't remember
		QuestionsTA

		Did you have questions you wanted to ask the second person you spoke to? - Yes - No - Not sure/ can't remember
		OpportunityTA Did you have the opportunity to ask these questions? - Yes - No - Not sure/ can't remember
UndstndTA When you had important questions to ask the telephone advisor, did you get answers you could understand? - Yes, completely - Yes, to some extent - No - Not sure/ can't remember	**UndstndTA** When you had important questions to ask the second person, did you get answers you could understand? - Yes, completely - Yes, to some extent - No - Not sure/ can't remember - I did not have any important questions	**UndstndTA** Did you get answers you could understand? - Yes, completely - Yes, to some extent - No - Not sure/ can't remember - I did not get any answers
InvolvTA Were you involved as much as you wanted to be in decisions about your care? - Yes, definitely - Yes, to some extent - No - Don't know / can't remember	**InvolvTA** Were you involved as much as you wanted to be in decisions about your care? - Yes, definitely - Yes, to some extent - No - Don't know / can't remember	
FearsTA If you had any anxieties or fears about your condition or treatment, did the telephone advisor discuss them with you? - Yes, completely - Yes, to some extent - No - I did not have anxieties or fears - Don't know / can't remember	**FearsTA** If you had any anxieties or fears about your condition or treatment, did the second person discuss them with you? - Yes, definitely - Yes, but I did not want to discuss these - No, but I wanted to discuss these - No, but I did not want to discuss these - I did not have anxieties or fears	**FearsTA** Did you have the opportunity to discuss any fears or anxieties with the second person you spoke with? - Yes and I did this - I could have done but didn't want to - No - I did not have anxieties or fears
ConfTA Did you have confidence in the telephone advisor? - Yes, completely - Yes, to some extent - No - Don't know / can't remember	**ConfTA** Did you have confidence in the second person you spoke with? - Yes, completely - Yes, to some extent - No - Don't know / can't remember	**ConfTA** Did you have confidence in the second person you spoke with? - Yes, completely - Yes, to some extent - No - Don't know / can't remember
InfoTA How much information did the caller taker give you about what they thought was wrong with you? - Too much - The right amount - Not enough - Don't know / can't remember		
ReassureTA Was the telephone advisor reassuring? - Yes, definitely - Yes, to some extent - No - Don't know / can't remember	**ReassureTA** Was the second person you spoke with reassuring? - Yes, definitely - Yes, to some extent - No - Don't know / can't remember	**ReassureTA** Was the second person you spoke with reassuring? - Yes, definitely - Yes, to some extent - No - Don't know / can't remember

DignityTA Were you treated with dignity and respect by the telephone advisor? - Yes, completely - Yes, to some extent - No - Don't know / can't remember	**DignityTA** Were you treated with dignity and respect by the second person you spoke with? - Yes, completely - Yes, to some extent - No - Don't know / can't remember	**DignityTA** Were you treated with dignity and respect by the second person you spoke with? - Yes, completely - Yes, to some extent - No - Don't know / can't remember
	AgreeTA Did you agree with the advice given to you by the second person? - Yes, definitely - Yes, to some extent - No - Don't know / can't remember - I was not given any advice	
	ExplainTA Did the second person explain the reason for this advice? - Yes, definitely - Yes, to some extent - No	
CallRefTA Were you referred to another service at any point during your call with the telephone advisor? - Yes - No - Don't know / can't remember	**CallRefTA** Were you referred to another service at any point during your call with the second person? - Yes - No - Don't know / can't remember	
ExplainRefTA Did the telephone advisor explain why your call was being referred? - Yes, completely - Yes, to some extent - No - Don't know / can't remember	**ExplainRefTA** Did the second person explain why your call was being referred? - Yes, completely - Yes, to some extent - No - Don't know / can't remember	
WhichRefTA Which service was your call referred to? - A GP at my local surgery - An out of hours GP - Accident & emergency services - Community care services - Some other health professional	**WhichRefTA** Which service was your call referred to? - A GP at my local doctor's surgery - An out of hours GP or other out of hours service e.g. NHS 111 - Hospital including accident & emergency services - Community care services - Some other health professional - other	**WhichRef** Which service did the ambulance service advise seeing? - A GP at my local doctor's surgery - An out of hours service e.g. GP - Hospital including accident & emergency services - Community care services - Another health professional - Other
ContactRefTA Did you have to make contact with this service yourself? - Yes - No, the telephone advisor did this for me - Don't know / can't remember	**ContactRefTA** Did you have to make contact with this service yourself? - Yes - No, the second person I spoke with did this for me - Don't know / can't remember	**ContactRef** Did the ambulance service make contact with this service? - Yes, the ambulance service did this - No, I did this for myself - No, I did this for the patient - Other - Don't know / can't remember
ApproRefTA	**ApproRefTA**	

Did you think the referral was appropriate? - Yes, definitely - Yes, to some extent - No - Don't know / can't remember	Did you think the referral was appropriate? - Yes, definitely - Yes, to some extent - No - Don't know / can't remember	
RefQualityTA How would you rate the quality of care you received from the service you were referred to? - Excellent - Very good - Good - Fair - Poor - Very poor - Not sure/ can't remember	**RefQualityTA** How would you rate the quality of care you received from the service you were referred to? - Excellent - Very good - Good - Fair - Poor - Very poor - Not sure/ can't remember	
InfoGivenTA Were you given instructions by the telephone advisor on what to do if the situation changed? - Yes - No - Don't know/ can't remember	**InfoGivenTA** Were you given instructions by the second person you spoke to on what to do if the situation changed? - Yes - No - Don't know/ can't remember - I was not given any instructions	
InfoFollowTA Were you able to follow the instructions given? - Yes, definitely - Yes, to some extent - No - Not sure/ can't remember	**InfoFollowTA** Were you able to follow the instructions given? - Yes, definitely - Yes, to some extent - No - Not sure/ can't remember	
InfoNFollowTA Why were you unable to follow the instructions? Outcome What happened at the end of your call with the ambulance service? - An ambulance was sent and I was taken to hospital - An ambulance crew or paramedic visited me but I didn't go to hospital - The ambulance service arranged an appointment for me with another health professional - I was referred to another health professional/ organisation - I was given advice on how to care for myself	**InfoNFollowTA** Why were you unable to follow the instructions ? Outcome What happened at the end of your call with the ambulance service? - An ambulance was sent and I was taken to hospital - I was told an ambulance would come, but it never arrived - An ambulance crew or paramedic visited me but I didn't go to hospital - The ambulance service arranged an appointment for me with another health professional - I was referred to another health professional/ organisation - I was given advice on how to care for myself - other	
Contact Did you have to contact another health professional within 48 hours due to the same condition? - Yes - No - Don't know/ Can't remember	**Contact** Did you have to contact another health professional within 48 hours due to the same condition? - Yes - No - Don't know/ Can't remember	**Contact** Was another health professional contacted within 48 hours about the same condition? - Yes - No - Not sure as I wasn't with the patient - Don't know/ Can't remember

WhoCont - The ambulance service for a second time - A GP at my local surgery - An out of hours GP - Accident & emergency services - Community care services - Some other health professional	**WhoCont** - Ambulance service via 999 - A GP at my local surgery - An out of hours GP or other out of hours service - Hospital including accident & emergency services - Community care services - Some other health professional - other	**WhoCont** - Ambulance service via 999 - A GP at my local surgery - An out of hours GP or other out of hours service - NHS 111/ NHS Direct - Hospital including accident & emergency services - Community care services - Some other health professional - other
Explain Did the member of staff explain why an ambulance would not be sent? - Yes, completely - Yes, to some extent - No - Don't know / can't remember	**Explain** Did the member of staff explain why an ambulance would not be sent? - Yes, completely - Yes, to some extent - No - Don't know / can't remember	**ExplainAdv** Did the ambulance service explain the reason for this advice? - Yes, definitely - Yes, to some extent - No - I did not want or need this explanation
Agree Did you agree with the decision not to send an ambulance? - Yes, completely - Yes, to some extent - No	**Agree** Did you agree with the decision not to send an ambulance? - Yes, completely - Yes, to some extent - No	**AgreeAdvice** Thinking about the advice given over the telephone, did you agree with this? - Yes, definitely - Yes, to some extent - No - Don't know / can't remember - I was not given any advice
		FollowAdvice Was it possible to follow the advice given?? - Yes, completely - Yes, to some extent - No - The advice was for the patient to follow - It was possible to follow the advice but I chose not to - Not sure/ can't remember
Recontact Were you able to follow the advice given by the ambulance service? - Yes, completely - Yes, to some extent - No - Don't know / can't remember		**ContactAS** How many times did you re-contact the ambulance service regarding this specific condition in the seven days following your call? - 0 - 1 - 2 - 3 or more times
Evaluate How would you rate the quality of care you received from the service you were referred to? - Excellent - Very good - Good - Fair - Poor - Very poor - Not sure/ can't remember		**ExplainAmb** Did the ambulance service explain why an ambulance would not be sent on this occasion? - Yes, completely - Yes, to some extent - No - Don't know / can't remember

Conditionworse Were you told what to do if your condition became worse? - Yes, completely - Yes, to some extent - No - Don't know / can't remember		**Did you agree with the decision not to send an ambulance?** - Yes, completely - Yes, to some extent - No
OverDignity Overall, did you feel you were treated with respect and dignity by the ambulance service? - Yes, always - Yes, sometimes - No	**OverDignity** Overall, did you feel you were treated with respect and dignity by the ambulance service? - Yes, always - Yes, sometimes - No	**OverDignity** Overall, did you feel you were treated with respect and dignity by the ambulance service? - Yes, always - Yes, sometimes - No
OverKind Overall, were you treated with kindness and understanding by the ambulance service? - Yes, all of the time - Yes, some of the time - No	**OverKind** Overall, were you treated with kindness and understanding by the ambulance service? - Yes, all of the time - Yes, some of the time - No	**OverKind** Overall, were you treated with kindness and understanding by the ambulance service? - Yes, all of the time - Yes, some of the time - No
OverallExp On a scale of 0 to 10 where 0 is 'I had a very poor experience' and 10 is 'I had a very good experience', how was your overall experience with the ambulance service?	**OverallExp** On a scale of 0 to 10 where 0 is 'I had a very poor experience' and 10 is 'I had a very good experience', how was your overall experience with the ambulance service?	**OverallExp** On a scale of 0 to 10 where 0 is 'I had a very poor experience' and 10 is 'I had a very good experience', how was your overall experience with the ambulance service?