

**Eye care services**

**October 16**

**DEVELOPING EYECARE PARTNERSHIPS**

**Make your voice heard and improve health care**

 **Help us to plan future services**

Have you or someone you know used **hospital based eye care services** during the past 2 years?

We want to make sure that your contact with our services is as effective, safe and comfortable as possible. In order to ensure this, we are asking, if you have had contact with these services from 1st July 2014 that you would tell us about your experience by completing the following survey.

This information will help us to improve eyecare services in the future.

***If you would like some help completing the survey or would like an alternative version made available please contact:*** ***0300 555 0114 (office hours).***

**Firstly could you tick which of the following best describes you:**

I am a patient who has used eye care services

I am completing the survey on a behalf of a person who has used eyecare services

Other (please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Your Story**

Please describe your experience of eye care services, whether as a patient, family member or as a carer.

Your experience can be about any aspect of eye care services, anywhere in Northern Ireland. We are interested in hearing about your overall experience and how this made you feel.

**Please note that by taking part in this service user experience survey you are consenting to your anonymous information being used in a variety of ways for example: in the development of reports, staff induction, staff education and training and for meetings, to improve the safety and quality of services and to influence how services are shaped for the future.**

 I consent to my anonymous information being used as described above.

Write your experience below. You can write as little or as much as you wish. Do not worry about spelling or grammar. We just want to know about your experience. Please do not provide the names of family members, caregivers or members of staff.

|  |
| --- |
| Your story (please feel free to add an extra page if need be ) |

**If you were to give your story a title what would that be?**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Is there anything that could have improved your experience?**

**Next Steps**

Please answer questions 1-5 to think further about your experience.

For each triangle, please mark the spot in each triangle which best reflects how you see your story.

* You can choose one specific corner if that fits best, or between two corners or in the middle if it is a bit of all three. Please see the example below:

**Example question: How is the weather today?**

**Dull**

Example question

This response indicates that the weather is dull

This response indicates that the weather is dull and cloudy

This response indicates that the weather is a mixture of sunny, dull and cloudy

**Sunny**

**Cloudy**

This response indicates that the weather is sunny

**Question 1: When you arrived at the department what was your first impression?**

**I felt welcome**

**I felt like I was just a number**

**Staff were abrupt**

**Question 2: Overall did you feel the staff were…..**

**Respectful and treated me with dignity**

**Dismissive**

**Unprofessional**

**Question 3: Did staff ensure your privacy and dignity were protected?**

**I felt that others could hear my personal information**

**Staff were very respectful and aware of my need for privacy**

**Staff talked about me as if I wasn’t there**

**Question 4: Did you find the information about your treatment was….?**

**Confusing/mixed**

**Not enough**

**Easy to understand**

**Question 5: When you left the clinic/department were you clear about what would happen next?**

**I was given clear instructions**

**I was confused about what would happen next**

**I was not given any information**

|  |
| --- |
| **Question 6: In general do staff introduce themselves to you?** |
| **Yes** |  |
| **No**  |  |
| **Comments** |

**Question 7: How did you feel about the appointment length?**

Thinking about your story, please consider the following scales, which use two extreme descriptions in relation to aspects of eyecare services. We would ask that you place an “X” on the scale where you feel your story sits in relation to the descriptions. If you feel that the statement does not apply to your story, please write “N/A” at the side of one of the descriptions.

It was too long

It was too short

**Question 8: What three factors were most important to you in getting to the clinic?**

|  |  |
| --- | --- |
|  |  **Comments** |
| **Car parking** |  |  |
| **Sign posting to the clinic** |  |  |
| **Ease of access to the clinic building** |  |  |
| **Transport** |  |  |
| **Getting time off work** |  |  |
| **Getting enough notice of appointment time** |  |  |
| **Appointment reminder** |  |  |
| **Other** |  |  |

**Question 9a: What is your preferred format for correspondence?**

|  |  |
| --- | --- |
| **Letter** |  |
| **Email** |  |
| **Text message** |  |
| **Other** |  |

|  |
| --- |
| **Question 9b: Do you receive appointment correspondence in your preferred format?** |
| **Always** |  |
| **Sometimes**  |  |
| **Never** |  |
| **Comments** |

**Question 10: After you had been referred to eyecare services were you satisfied with the waiting time before you received your first appointment?**

|  |  |
| --- | --- |
| **Yes** |  |
| **No**  |  |
| **Comments** |

**Question 11: Were you involved in decisions about your treatment/care as much as you would have liked?**

|  |
| --- |
|  |
| **Yes** |  |
| **No – I would have liked to be more involved** |  |
| **No – I would have liked to be less involved** |  |
| **Can't remember / not sure** |  |

**Question 12: While you were waiting did you find the facilities..? (Please tick as many as apply)**

|  |  |
| --- | --- |
| **Comfortable** |  |
| **Clean and tidy**  |  |
| **Cramped** |  |
| **There were not enough chairs**  |  |
| **Toilets were very clean**  |  |
| **Toilets were not clean**  |  |
| **There were not enough toilets** |  |
| **Too hot** |  |
| **Too cold** |  |
| **Noisy** |  |
| **Had facilities for drinks and snacks**  |  |
| **Please add any comments**  |

**Question 13: When you visit an eye clinic do you receive information about other professional and support services available to you?**

|  |  |
| --- | --- |
| **Yes** |  |
| **No** |  |
| **Sometimes** |  |

|  |
| --- |
| **Question 14: In your eye care experience, which of the following professional and support services were you involved with? Tick all that apply** |
| Community/High Street Optometrist |  |
| General Practitioner (GP) |  |
| Hospital Reception/Administration Staff |  |
| Nursing Staff |  |
| Nursing Auxiliary |  |
| Doctor or Consultant Ophthalmologist |  |
| Technician |  |
| Hospital Optician/Optometrist |  |
| Eye Care Liaison Officer (ECLO) |  |
| Eye Care Liaison Officer Support Volunteer |  |
| Health Care Assistant |  |
| Nurse Practitioner |  |
| Low Vision Service |  |
| Sensory Support Team |  |
| Interpreting Services |  |
| RNIB Helpline |  |
| Other RNIB Service |  |
| Macular Society |  |
| International Glaucoma Association |  |
| Other Patient Support Group or Charity |  |
| Volunteers |  |
| Domestic Services |  |
| Hospital Porter Staff |  |

**Question 15: Did you attend any of the following services? (Tick as many as apply)**

|  |  |
| --- | --- |
| Macular service |  |
| Diabetic eye service |  |
| Glaucoma service |  |
| General ophthalmology outpatient |  |
| In patient or day case surgery |  |
| POPCC (Paediatric Ophthalmology Priority Consultation Clinic) |  |
| Low vision clinic |  |
| ECLO (Eyecare Liaison Officer)  |  |
| Eye Casualty  |  |
| Other (please specify) |  |

**Question 16: Did you attend the clinic/department because of any of the following conditions?**

|  |  |
| --- | --- |
| Macular(including age related macular degeneration, retinal vein occlusion, diabetic macular oedema) |  |
| Diabetic eye disease |  |
| Glaucoma |  |
| Cataract |  |

**Question17: Overall how would you rate your experience?**

|  |  |
| --- | --- |
| Strongly positive |  |
| Positive  |  |
| Neutral |  |
| Negative |  |
| Strongly negative |  |
| Not sure |  |

**Question 18: Where was the clinic located?**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Question 18: What are the first 4 digits in your postcode? (e.g. BT66)**

**The details below apply to the person the story relates to**

All responses will be treated within the principles of confidentiality and anonymity. Use of monitoring information will involve statistical summaries only. No information which could be used to identify you will be made available in any way. All responses are processed in line with our strict and robust data protection obligations.

**Age What is your country of birth?**

|  |  |
| --- | --- |
| 0-18 years |  |
| 19 – 29 years |  |
| 30 – 39 years |  |
| 40- 49 years |  |
| 50 – 59 years |  |
| 60- 69 years |  |
| 70 – 79 years |  |
| 80+ |  |

|  |  |
| --- | --- |
| Northern Ireland |  |
| England |  |
| Wales |  |
| Scotland |  |
| Republic of Ireland |  |
| Elsewhere, write in the current name of the country |  |

**Your sexual orientation Your Gender**

|  |  |
| --- | --- |
| Hetrosexual |  |
| Lesbian |  |
| Bi-sexual |  |
| Gay |  |
| Prefer not to comment |  |

|  |  |
| --- | --- |
| Male |  |
| Female |  |
| Transgender |  |
| Prefer not to comment |  |

 **What is your Ethnic Group?**

|  |  |
| --- | --- |
| White |  |
| Chinese |  |
| Irish Traveller |  |
| Indian |  |
| Pakistani |  |
| Bangladeshi |  |
| Black Caribbean |  |
| Black African |  |
| Black (other) |  |
| Mixed ethnic group  |  |
| Any other ethnic group  |  |

**Disability**
**In accordance with the Disability Discrimination Act 1995, a disability is defined as a physical or mental impairment which has a substantial and long-term effect on a person's ability to carry out normal day-to-day activities.**

Under this definition, do you consider yourself as having a disability?

 Yes **□** No **□** Prefer not to say **□**

**If yes, please indicate which type of impairment(s) applies to you.**

|  |  |
| --- | --- |
| Physical Impairment |  |
| Sensory Impairment |  |
| Mental health condition |  |
| Learning disability |  |
| Long standing illness |  |

**Are you registered with sight impairment?**

|  |  |
| --- | --- |
| **Yes** |  |
| **No** |  |

**Please indicate if you (or the person) are living with a rare disease, a probable diagnosis of a rare disease, or a ‘syndrome without a name’ (SWAN). A rare disease is one that affects less than 5 in 10,000 of the general population.**

|  |  |
| --- | --- |
| **Yes** |  |
| **No** |  |

 **If known, specify the condition:**

Thank you for taking the time to complete this survey, we really appreciate it.

If you are completing a paper copy, please return to the Freepost address below:

Public Health Agency

Nursing, Safety, Quality & Patient Experience

12-22 Linenhall Street

Belfast

BT2 8BS

**Support**

You may find that you would like to have someone to talk to about your responses to the questions – a friend or family member, or someone who provides you with support. You can also contact the helpline: Telephone **0300 555 0114 (office hours)**