Report on the self reported experience of patients from black and minority ethnic groups

June 2009

1. Executive summary

This report examines variations in the self-reported views of NHS patients from different ethnic groups and presents results from the 2008/09 adult inpatient, 2008/09 emergency department, 2007/08 primary care services and 2007/08 community mental health patient surveys. These results give us insight into the areas of NHS service provision where experience of the service looks different to patients from different ethnic groups. Results are based on data from the National Patient Survey programme, led by the Care Quality Commission.

Some ethnic groups are very small, relative to the overall size of the population, and the small number of responses from these groups means that the data contain a limited amount of information about ethnic variations. The Department of Health and the Care Quality Commission have worked together to find a way to analyse the data in other ways to allow comparisons to be made.

Attention focuses on how likely patients are to give 'positive' answers to each patient survey question. A number called the 'odds ratio' is used to show whether a particular ethnic category is more likely or less likely to give a positive answer when compared with White British respondents. If the odds ratio (and its margin of error) are above 1, then that group has reported better experience, whilst if the odds ratio (and its margin of error) are below 1, the reported experience of that group is worse.

The results may be influenced by differences in perception as well as physical differences in experience (for example, where patients see the same ward but have a different perception of its cleanliness). Results are best used to interpret broad patterns, rather than focussing on individual categories or questions.

The main findings are:

- Results show a range of variations between black and minority ethnic (BME) groups and their white British counterparts. Where differences do exist, most are negative, indicating that BME groups are less likely to report a positive experience. However many areas show no difference with some showing a positive difference.

- Patients from the White Irish group were more likely to give positive responses, across the majority of questions, compared with the White British baseline.

- Patients from the Asian and Chinese/Other groups were less likely to give positive responses compared with the White British group).

- Patients from the White Other and Mixed groups were again typically less likely to give positive responses, but less consistently than the Asian and Chinese groups.

- Results for Black patients were mixed, although they were slightly less likely to give positive responses, particularly in the primary care and A&E surveys.

- BME groups tended to be less positive about questions relating to 'access and waiting' or to 'better information and more choice'.

- Across survey settings, differences were seen most in the primary care survey, where all BME groups (except the White Irish) were less likely to give positive

2

responses. Very few differences were found in the community mental health survey.

This is the second time this analysis has been undertaken (the first BME report was published in May 2008[1]) and therefore it is possible to gain some impression of how results have changed over time. Overall, there are relatively few changes between the previous analysis and this one. The same general patterns are apparent, both in terms of results for groups and when looking at particular sets of questions.

---

[1] The first BME report was published in May 2008 on the Department of Health website at:
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsStatistics/DH_084921

Report on self reported experience of patients from black and minority ethnic groups

2. Introduction

This report updates the previous analysis published in May 2008[2] and examines variations in the self-reported views of NHS patients from different ethnic groups. These results give us insight into the areas of NHS service provision where experience of the service looks different to patients from diverse ethnic groups. The variations in experience reported here could reflect real inter-group differences in the quality of services received, or inter-group differences in subjective factors such as expectations or perceptions, or some combination of these factors.

Exploring these differences is important, and is part of an established programme of work by the Department of Health and the Care Quality Commission to report on the experiences of patients. This work is underpinned by a national programme of surveys that examine the experience of patients in the NHS in England. The survey programme systematically collects structured and systematic feedback on the quality of service delivery from the patient and service users. This provides objective measures of NHS performance – at organisation level and both regionally and nationally.

Results in this report are based on the National Patient Survey Programme. This is the most substantial source of survey data across a range of different healthcare settings and a range of different aspects of patient experience. There are other data sources, including the GP patient survey, which has a very large sample size but focuses on patient experience of primary care. Results from the GP patient survey are not considered here, but have been used by the Department to support the review by Professor Mayur Lakhani of why patients from black and ethnic minority (BME) groups find it more difficult to access GP services than white populations.[3]

2.1. Targets in this area

This report is designed to address a specific commitment in "National Standards, Local Action"[4] to report on the experience of patients from BME groups. This commitment needs to be seen in the broader context of overall targets to improve patient experience. In 2002 the Department of Health agreed a target for the measurement of trends in patient experience as part of its Public Services Agreement (PSA) with HM Treasury to:

> *Enhance accountability to patients and the public and secure sustained national improvements in patient experience as measured by independently validated national surveys[5].*

This was rolled forward in a slightly amended form in 2004:

---

[2] The first BME report was published in May 2008 on the Department of Health website at:
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsStatistics/DH_084921
[3] The Lakhani report was published in May 2008 on the Department of Health website at:
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_084971
[4] Further details are available at:
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4086057
[5] Further details for SR2002 are available via the Department of Health website:
http://www.dh.gov.uk/en/Aboutus/HowDHworks/Servicestandardsandcommitments/DHPublicServiceAgreement/DH_074514

Secure sustained annual national improvements in NHS patient experience by 2008, as measured by independently validated surveys, ensuring that individuals are fully involved in decisions about their healthcare, including choice of provider[6].

It was rolled forward again in the same form, as one of the indicators in the 2008-11 PSA delivery agreement 19: "ensure better care for all".

These results also relate to responsibilities under equality and human rights legislation to monitor variations in service provision for different groups. They also address the Care Quality Commission's commitment to monitor the experiences of minority ethnic groups and to promote equality.

2.2. The national patient survey programme – scoring patient experience

The national patient survey programme is a well-established feature of healthcare regulation in England. The Care Quality Commission publishes all the data at individual trust level and uses it in its annual assessment of NHS trusts – the Annual Health Check. Each survey consists of responses from individual respondents (around 14,000 useable responses for the smallest survey and up to 76,000 for the largest). Each respondent answers around 50 questions about their experience per survey.

To report on overall targets for improvements in patient experience, a subset of questions has been identified in advance to represent findings against each of five key domains of patient experience. Responses to these questions are converted into scores out of 100 using a scoring schema, and results are then standardised by age and gender (and in the case of adult inpatient data, by admission method too). Scores are then aggregated to form five domain scores:

- Access & waiting
- Safe, high quality, co-ordinated care
- Better information, more choice
- Building closer relationships
- Clean, comfortable, friendly place to be[7]

Overall national scores for these five domains are routinely published on the Department of Health website[8]. This methodology was agreed between the Department of Health and the Care Quality Commission (then the Healthcare Commission).

---

[6] Further details for SR2004 are available via the Department of Health website:
http://www.dh.gov.uk/en/AboutUs/HowDHWorks/ServiceStandardsAndCommitments/DHPublicServiceAgreement/DH_4106188
[7] This domain is not included in the Mental Health service survey.
[8] The publication can be found at:
http://www.dh.gov.uk/en/Publicationsandstatistics/PublishedSurvey/NationalsurveyofNHSpatients/index.htm

3. Methods

In theory the same methodology could be used to calculate scores for individual ethnic categories, to allow a direct comparison. However, some ethnic categories form a relatively small proportion of the population. Even in these large surveys, the number of respondents from most minority ethnic groups is small. Whilst it is possible to calculate notional scores using the above methods, the confidence intervals are very large and it is not possible to say reliably whether the scores differ by ethnic group.

The Care Quality Commission (then the Healthcare Commission) and Department of Health worked together to develop an alternative methodology that allows results for different ethnic groups to be presented. The aim was to establish a standard methodology for reporting on the data that can be applied in a consistent way across healthcare settings and across time. Annex B describes the process used to narrow down the range of possible analytical techniques and to define the approach used in this report.

In brief, the small number of responses for some ethnic groups limits the amount of information in the data. The methodology makes maximum use of the available information by:

   a) considering responses to individual questions rather than overall domains (since this means that we can ignore missing values in calculating average scores).

   b) grouping some BME groups, where appropriate, to increase the base size of the group

   c) grouping responses to the multiple-choice questions to create binary responses (positive/ negative)

   d) focusing on differences from a baseline group rather than absolute scores (we use White: British as the baseline group because it is by far the largest group)

A technique called logistic regression was used to build a model to measure the extent to which positive or negative results can be explained by the ethnic group of the respondent, which also take into account factors such as age and gender. The result is a number called an 'odds ratio' which serves as a score giving an indication of whether the responses of people within each aggregate ethnic group are more or less likely to be positive than those for White British respondents. Scores are calculated for each 'PSA question' in the most recent surveys conducted in four different clinical settings:

   • survey of adults who use inpatient departments (2008/09)
   • survey of people who use emergency departments (2008/09)
   • survey of people who use local health services (Primary Care Trusts) (2007/08)
   • survey of people who use community mental health services (2007/08)

The results presented in this report are at national level and provide useful insights into the way that patient-reported views can vary across ethnic groups. Annex A

provides details on how to interpret the results in the tables and on some caveats that should be kept in mind when looking at the results.

4. Results within the patient surveys

The following section provides a descriptive summary of the results in each of the four care settings. This summary is accompanied by small tables showing the results for particular aspects of care. These tables are extracts from the full set of results in Annex C. They have been simplified here, and also colour coded to make interpretation easier:

Key

i) Cells with a beige-pink colour like this indicate that positive responses are significantly less likely than for the White British baseline

ii) Cells with a green colour like this indicate that responses are significantly more likely to be positive than for the White British baseline

iii) Cells with no shading indicate no statistically significant difference from the White British baseline in the likelihood of responding positively

4.1. National Survey of Adult Inpatients 2008/09

The acute adult inpatient survey, which collected information on the experience of people who had recently been discharged from hospital following a stay of at least one night, showed mixed patterns of variations between different ethnic groups. Whilst in some areas patients from BME groups were less likely to give positive responses, there were others where they tended to be more positive than White British patients.

The **access and waiting** domain was one area that showed a clear trend towards people from BME groups being less likely to give positive responses. This was particularly true of patients from the Mixed, Asian, and Black groups, who were significantly less likely to respond positively to all three of the questions in this domain. People from the Chinese and White Other groups responded less positively on two items, but the exception was the White Irish group, who were significantly more likely to give positive responses to two of the questions. This can be seen in Table 1.

Table 1: Results for 'access and waiting' domain

Access and Waiting	White: Irish	White: Other	Mixed	Asian/Asian British	Black/black British	Chinese/ other
Was your admission date changed by the hospital?	1.14	0.88	0.68	0.74	0.71	1.02
	(0.89, 1.46)	(0.72, 1.07)	(0.48, 0.97)	(0.59, 0.93)	(0.55, 0.93)	(0.54, 1.96)
How do you feel about the length of time you were on the waiting list before your admission to hospital?	1.34	0.65	0.50	0.55	0.87	0.54
	(1.05, 1.72)	(0.54, 0.78)	(0.36, 0.70)	(0.45, 0.68)	(0.67, 1.13)	(0.31, 0.94)
From the time you arrived at the hospital, did you feel that you had to wait a long time to get to a bed on a ward?	1.19	0.76	0.76	0.58	0.68	0.54
	(1.02, 1.38)	(0.67, 0.85)	(0.61, 0.96)	(0.51, 0.66)	(0.58, 0.79)	(0.38, 0.76)

Likewise, patients from BME groups were often less likely than White British patients to give positive responses to questions in the **building relationships with staff** domain. This was most pronounced amongst respondents from Asian groups, who were significantly less likely to give positive responses on all four questions within the domain. With the exception of the White Irish group, who were more likely to give positive responses on three of the four questions, all other ethnic groups were less likely to be positive on between one and three of the items. This was especially

marked when people were asked whether nurses "talk in front of you as if you weren't there": with the exception of the White Irish respondents, patients from each of the BME groups were less likely than White British respondents to give a favourable account of their experience. This can be seen in Table 2.

Table 2: ***Results for 'building relationships with staff' domain***

Building relationships	White: Irish	White: Other	Mixed	Asian/Asian British	Black/black British	Chinese/ other
When you had important questions to ask the doctor, did you get answers that you could understand?	1.35 (1.16, 1.59)	0.85 (0.75, 0.95)	0.72 (0.58, 0.90)	0.78 (0.68, 0.89)	0.92 (0.78, 1.08)	0.74 (0.53, 1.05)
Did doctors talk in front of you as if you weren't there?	1.13 (0.97, 1.31)	0.84 (0.75, 0.95)	0.70 (0.56, 0.87)	0.67 (0.59, 0.77)	1.05 (0.89, 1.24)	0.90 (0.63, 1.30)
When you had important questions to ask a nurse, did you get answers that you could understand?	1.26 (1.09, 1.47)	0.92 (0.82, 1.03)	0.84 (0.67, 1.04)	0.63 (0.55, 0.72)	0.86 (0.74, 1.01)	0.54 (0.38, 0.76)
Did nurses talk in front of you as if you weren't there?	1.18 (1.00, 1.39)	0.72 (0.64, 0.81)	0.47 (0.38, 0.59)	0.44 (0.39, 0.51)	0.75 (0.64, 0.89)	0.62 (0.44, 0.89)

Trends in the other three domains were typically less clear, though. For questions in the **safe, high quality, co-ordinated care domain**, patients from BME groups gave similar or more positive reports of their experiences than patients from the White British group. Few significant differences were observed, but respondents in the White Irish group were significantly more likely to give positive responses to all three of the questions in the domain (see Table 3).

Table 3: ***Results for 'safe, high quality, co-ordinated care' domain***

Safe, high quality, coordinated care	White: Irish	White: Other	Mixed	Asian/Asian British	Black/black British	Chinese/ other
Sometimes, a member of staff will say one thing and another will say something quite different. Did this happen to you?	1.20 (1.04, 1.38)	1.01 (0.90, 1.13)	1.03 (0.84, 1.28)	0.93 (0.82, 1.06)	1.02 (0.87, 1.19)	1.22 (0.86, 1.73)
On the day you left hospital, was your discharge delayed for any reason?	1.18 (1.03, 1.35)	1.06 (0.95, 1.19)	1.09 (0.89, 1.35)	1.16 (1.02, 1.32)	1.02 (0.88, 1.19)	1.28 (0.91, 1.80)
Did a member of staff tell you about any danger signals you should watch for after you went home?	1.51 (1.30, 1.76)	1.08 (0.95, 1.23)	0.93 (0.73, 1.17)	0.91 (0.79, 1.05)	1.03 (0.87, 1.22)	0.99 (0.67, 1.46)

Results in the remaining two domains (**better information, more choice** and **clean, comfortable, friendly place to be**) showed more variation in the propensity of groups to give positive responses. Again, patients from White Irish groups were significantly more likely to give positive responses to the majority of questions, but other groups were typically more likely to be positive about some areas and less likely to be so about others. Three questions proved exceptions to this. Most respondents from BME groups were significantly more likely to say that they were not bothered by noise at night, whether from hospital staff or from other patients, (see Table 4). Conversely people from all BME groups, other than White Irish, were significantly less likely to respond positively when asked if they have been as involved as they would have liked in decisions made about their care (see Table 5).

Table 4: ***Results for 'clean, comfortable, friendly place to be' domain***

Clean, comfortable, friendly place to be	White: Irish	White: Other	Mixed	Asian/Asian British	Black/black British	Chinese/ other
Were you ever bothered by noise at night from other patients?	1.43 (1.25, 1.65)	1.01 (0.90, 1.13)	1.34 (1.08, 1.65)	1.22 (1.07, 1.39)	1.54 (1.32, 1.80)	1.02 (0.73, 1.43)
Were you ever bothered by noise at night from hospital staff?	1.44 (1.21, 1.72)	1.12 (0.98, 1.28)	1.18 (0.92, 1.51)	1.50 (1.27, 1.77)	1.87 (1.53, 2.28)	1.78 (1.14, 2.77)
In your opinion, how clean was the hospital room or ward that you were in?	1.33 (1.16, 1.53)	0.82 (0.73, 0.91)	0.98 (0.80, 1.21)	0.59 (0.52, 0.67)	0.89 (0.77, 1.04)	0.53 (0.38, 0.75)
How would you rate the hospital food?	1.10 (0.96, 1.26)	1.00 (0.90, 1.12)	1.07 (0.86, 1.32)	0.97 (0.85, 1.11)	0.92 (0.79, 1.08)	0.70 (0.49, 0.99)
Were you given enough privacy when being examined or treated?	1.18 (0.95, 1.47)	0.87 (0.75, 1.02)	0.83 (0.63, 1.08)	0.87 (0.73, 1.03)	1.22 (0.98, 1.51)	0.56 (0.38, 0.83)
Overall, did you feel you were treated with respect and dignity while you were in the hospital?	1.50 (1.25, 1.79)	0.96 (0.84, 1.09)	0.91 (0.72, 1.14)	0.80 (0.69, 0.92)	0.96 (0.81, 1.13)	0.85 (0.59, 1.23)
Do you think the hospital staff did everything they could to help control your pain?	1.29 (1.07, 1.56)	0.88 (0.77, 1.02)	0.88 (0.69, 1.13)	0.72 (0.62, 0.84)	0.97 (0.81, 1.16)	0.64 (0.43, 0.94)

Table 5: Results for 'better information, more choice' domain

Better information, more choice	White: Irish	White: Other	Mixed	Asian/Asian British	Black/black British	Chinese/other
Were you involved as much as you wanted to be in decisions made about your care and treatment?	1.31	0.83	0.68	0.71	0.76	0.70
	(1.15, 1.50)	(0.74, 0.92)	(0.55, 0.84)	(0.63, 0.81)	(0.66, 0.89)	(0.50, 0.97)
Did a member of staff explain the purpose of the medications you were to take at home in a way you could understand?	1.35	0.94	1.14	0.86	1.17	0.93
	(1.13, 1.62)	(0.82, 1.08)	(0.87, 1.49)	(0.74, 1.00)	(0.97, 1.42)	(0.61, 1.42)
Did a member of staff tell you about medication side effects to watch for when you went home?	1.96	1.15	0.98	0.89	1.19	1.45
	(1.67, 2.30)	(1.00, 1.31)	(0.77, 1.25)	(0.76, 1.03)	(1.00, 1.41)	(0.98, 2.13)

Overall, patterns of variation across ethnic groups on the inpatients survey are mixed, with most BME groups being more positive than the White British baseline on some areas, less positive on others, and no different elsewhere. Exceptions were the White Irish respondents, who showed no negative differences and were significantly more likely to respond favourably on all bar four of the twenty questions assessed.

The results for the inpatients survey are broadly similar to those observed when the analysis was last undertaken using data from the 2006/07 survey. By and large, the results do not suggest substantial change in the overall patterns; in most cases differences that are significant in one analysis but not the other are approaching significance in the latter, suggesting that actual changes have been relatively small. However, absolute changes within ethnic groups were not tested, so it is not possible from this analysis to determine whether any individual group has become more or less likely to give positive responses to particular questions since the previous survey.

4.2. National Survey of users of emergency departments 2008/09

This survey looked at the experiences of people who had recently attended an accident and emergency (A&E) department. The results for this survey showed clearer patterns than the inpatients survey, with a general trend for people from several BME groups to be less likely to give positive responses on a range of areas. This was particularly true of people from Asian/Asian British, White Other, and Chinese/other ethnic groups. People from Black/Black British and Mixed ethnic groups showed fewer significant differences, whilst White Irish respondents again tended to be more positive in their responses.

As in the inpatients survey, patients from BME groups tended to be less likely to report good experiences around **access and waiting** (see Table 6). The delay between arrival and first speaking to a nurse or doctor appeared to be a particular issue with people from all BME groups (other than the White Irish group). Asian and Chinese/other respondents gave less positive responses across all questions on this domain.

Table 6: Results for 'access and waiting' domain

Access and Waiting		White: Irish	White: Other	Mixed	Asian/Asian British	Black/black British	Chinese/other
From the time you first arrived at the Emergency Department, how long did you wait before being examined by a doctor or nurse practitioner?	Odds ratio	1.06	0.86	0.88	0.72	0.97	0.60
	95%	(0.87, 1.29)	(0.76, 0.96)	(0.72, 1.08)	(0.65, 0.81)	(0.84, 1.11)	(0.45, 0.79)
Overall, how long did your visit to the Emergency Department last?	Odds ratio	0.95	0.92	0.91	0.86	1.07	0.67
	95%	(0.78, 1.14)	(0.82, 1.05)	(0.74, 1.12)	(0.77, 0.97)	(0.93, 1.24)	(0.50, 0.90)
How long did you wait before you first spoke to a nurse or doctor?	Odds ratio	1.05	0.70	0.77	0.58	0.68	0.64
	95%	(0.86, 1.26)	(0.63, 0.79)	(0.63, 0.94)	(0.52, 0.64)	(0.60, 0.78)	(0.48, 0.84)

Very similar patterns were observed in the **safe, high quality, coordinated care** domain. Once again, respondents from Asian and Chinese groups were significantly less likely to give a positive response to all three questions, whilst people from White Other and Black groups gave significantly less positive responses in one and two questions respectively. There were no significant differences amongst the White Irish or Mixed groups (see Table 7).

Table 7:   Results for 'safe, high quality, coordinated care' domain

Safe, high quality, coordinated care		White: Irish	White: Other	Mixed	Asian/Asian British	Black/black British	Chinese/other
Sometimes in a hospital, a member of staff will say one thing and another will say something quite different. Did this happen to you?	Odds ratio	0.98	0.82	0.90	0.63	1.06	0.57
	95%	(0.78, 1.22)	(0.72, 0.94)	(0.72, 1.12)	(0.56, 0.70)	(0.91, 1.25)	(0.42, 0.77)
Did a member of staff tell you about any danger signals regarding your illness or treatment to watch for after you went home?	Odds ratio	1.23	0.90	1.08	0.70	0.79	0.53
	95%	(0.96, 1.59)	(0.77, 1.04)	(0.84, 1.39)	(0.60, 0.82)	(0.66, 0.95)	(0.35, 0.79)
Did you have confidence and trust in the doctors and nurses examining and treating you?	Odds ratio	1.16	0.67	0.86	0.78	0.90	0.56
	95%	(0.95, 1.41)	(0.60, 0.75)	(0.71, 1.05)	(0.70, 0.87)	(0.79, 1.03)	(0.43, 0.74)

There were mixed results in the **better information, more choice** domain. Once again, White Irish respondents were similar to the White British baseline group, although they were significantly more likely to say that they had been involved as much as they wanted to be in decisions about their care and treatment. All other BME groups were significantly less likely than the White British baseline to report that they were given enough information about their condition or treatment. However, there were no significant differences when patients were asked whether they were told about possible side effects of medication that they had been prescribed. On all other questions, respondents from Asian and Chinese groups were less likely to give positive responses. By contrast, Black/Black British respondents were significantly more likely to give favourable responses when asked if hospital staff had explained the purpose of medicines to them. These results are shown in Table 8.

Table 8:   Results for 'better information, more choice' domain

Better information, more choice		White: Irish	White: Other	Mixed	Asian/Asian British	Black/black British	Chinese/other
Were you involved as much as you wanted to be in decisions about your care and treatment?	Odds ratio	1.20	0.59	0.84	0.58	0.68	0.46
	95%	(1.01, 1.44)	(0.53, 0.66)	(0.69, 1.02)	(0.52, 0.64)	(0.60, 0.78)	(0.35, 0.61)
Did a member of staff explain the purpose of the medications you were to take at home in a way you could understand?	Odds ratio	0.97	0.82	1.13	0.77	1.35	0.50
	95%	(0.62, 1.54)	(0.65, 1.03)	(0.73, 1.75)	(0.62, 0.95)	(1.00, 1.83)	(0.31, 0.81)
Did a member of staff tell you about medication side effects to watch for?	Odds ratio	1.27	1.08	1.02	1.02	0.85	0.78
	95%	(0.87, 1.86)	(0.89, 1.32)	(0.72, 1.47)	(0.84, 1.23)	(0.67, 1.09)	(0.48, 1.27)
While you were in the Emergency Department, how much information about your condition or treatment was given to you?	Odds ratio	0.97	0.78	0.80	0.85	0.82	0.66
	95%	(0.79, 1.17)	(0.69, 0.88)	(0.65, 0.98)	(0.76, 0.95)	(0.71, 0.94)	(0.49, 0.88)

In the **building relationships with staff** domain, respondents from all BME groups with the exception of White Irish were significantly more likely to say that doctors and nurses talked in front of them as if they weren't there, this was also true of the inpatients survey. By contrast, no significant differences were observed on the question about whether doctors and nurses listened to what patients had to say – although results for the White Irish and Black British groups were approaching significance for being more likely to give positive responses than the White British baseline. There was a consistent pattern across the remaining three questions in the domain: White Irish respondents were significantly more likely to answer favourable, whilst White Other, Asian, and Chinese groups were less so. No other differences were observed in the Mixed or Black groups, as shown in Table 9.

Table 9:   Results for 'building relationships with staff' domain

Building relationships		White: Irish	White: Other	Mixed	Asian/Asian British	Black/black British	Chinese/other
Did doctors or nurses talk in front of you as if you weren't there?	Odds ratio	0.99	0.48	0.48	0.38	0.72	0.40
	95%	(0.79, 1.25)	(0.42, 0.54)	(0.39, 0.59)	(0.34, 0.42)	(0.61, 0.84)	(0.30, 0.54)
Did you have enough time to discuss your health or medical problem with the doctor or nurse?	Odds ratio	1.30	0.74	0.86	0.80	1.03	0.69
	95%	(1.07, 1.57)	(0.66, 0.83)	(0.71, 1.05)	(0.72, 0.89)	(0.90, 1.18)	(0.53, 0.91)
While you were in the Emergency Department, did a doctor or nurse explain your condition and treatment in a way you could understand?	Odds ratio	1.28	0.89	0.88	0.83	0.93	0.71
	95%	(1.06, 1.54)	(0.79, 0.99)	(0.72, 1.07)	(0.75, 0.92)	(0.82, 1.06)	(0.54, 0.93)
Did the doctors and nurses listen to what you had to say?	Odds ratio	1.21	0.92	0.95	0.91	1.15	0.89
	95%	(0.99, 1.48)	(0.82, 1.04)	(0.77, 1.17)	(0.81, 1.02)	(0.99, 1.33)	(0.66, 1.20)
If you had any anxieties or fears about your condition or treatment, did a doctor or nurse discuss them with you?	Odds ratio	1.26	0.87	1.03	0.80	1.05	0.66
	95%	(1.03, 1.52)	(0.77, 0.98)	(0.83, 1.28)	(0.71, 0.89)	(0.91, 1.21)	(0.48, 0.89)

The **clean, comfortable, friendly place to be** domain showed a similar pattern of results. Again, one question, whether people were given enough privacy when being examined or treated, showed no significant differences. Conversely, all groups except the White Irish were significantly less likely to report that they had been treated with dignity and respect whilst in the emergency department. For the remaining two questions in the domain, White Irish respondents were significantly

more likely to give positive responses whilst White Other, Asian, and Chinese respondents were less likely to answer favourably. This is shown in Table 10.

Table 10:   **Results for 'clean, comfortable, friendly place to be' domain**

Clean, comfortable, friendly place to be		White: Irish	White: Other	Mixed	Asian/Asian British	Black/black British	Chinese/ other
In your opinion, how clean was the Emergency Department?	Odds ratio	1.23	0.84	1.19	0.78	1.06	0.54
	95%	(1.04, 1.45)	(0.75, 0.94)	(0.97, 1.45)	(0.69, 0.87)	(0.92, 1.21)	(0.39, 0.74)
Were you given enough privacy when being examined or treated?	Odds ratio	0.98	0.90	0.94	0.94	1.13	0.82
	95%	(0.81, 1.20)	(0.80, 1.02)	(0.76, 1.17)	(0.84, 1.06)	(0.97, 1.31)	(0.61, 1.11)
Overall, did you feel you were treated with respect and dignity while you were in the Emergency Department?	Odds ratio	1.10	0.74	0.79	0.66	0.83	0.54
	95%	(0.89, 1.36)	(0.66, 0.84)	(0.65, 0.97)	(0.59, 0.74)	(0.72, 0.95)	(0.41, 0.71)
Do you think the hospital staff did everything they could to help control your pain?	Odds ratio	1.45	0.83	0.98	0.69	0.86	0.73
	95%	(1.15, 1.83)	(0.73, 0.96)	(0.78, 1.24)	(0.61, 0.79)	(0.74, 1.01)	(0.52, 1.02)

Overall, results from the emergency department survey showed some similarity to those from the inpatients survey. Once again, patients from White Irish groups were the exception in tending to be similar to, or more positive than, the White British baseline. The White Other, Asian, and Chinese groups were typically less likely to give positive responses across a range of areas. Relatively few differences were observed within the Mixed and Black groups.

On the whole, the results were similar to those observed in the previous emergency departments' survey, which was conducted in 2004/05. As with the inpatients survey, there is little clear evidence of changes in the overall patterns between ethnic groups. Again, it is important to note that absolute changes within ethnic groups were not tested, so it is not possible from this analysis to see whether any individual group has become more or less likely to give positive responses to any particular questions since the previous survey.

4.3. National Survey of local health services 2007/08

Unlike other national surveys organised by the Care Quality Commission, the national survey of local health services does not select participants on the basis of a recent care episode. Rather, individuals are selected based on being registered with a GP, so the survey covers the experiences of the community as a whole with respect to a range of issues in primary care.

Asian and Chinese respondents were significantly less likely to give positive responses to all three questions in the **access and waiting** domain. Respondents from Mixed and Black ethnic groups were also significantly more likely to report longer waits after their appointment time than White British respondents, with White Irish respondents the exception in being significantly more favourable around this issue. Other results in the domain showed few differences, although it is notable that Black and Black British respondents were significantly more likely to report a short waiting time to get an appointment (see Table 11).

Table 11:   ***Results for 'access and waiting' domain***

Access and Waiting		White: Irish	White: Other	Mixed	Asian/Asian British	Black/black British	Chinese/ other
The last time you saw a doctor from your GP surgery did you have to wait for an appointment?	Odds ratio	1.07	0.89	0.96	0.75	1.22	0.64
	95%	(0.90, 1.27)	(0.79, 0.99)	(0.78, 1.19)	(0.67, 0.83)	(1.06, 1.39)	(0.50, 0.80)
How long after your appointment time did you have to wait to be seen?	Odds ratio	1.26	0.79	0.70	0.57	0.76	0.56
	95%	(1.05, 1.51)	(0.71, 0.89)	(0.58, 0.86)	(0.51, 0.62)	(0.66, 0.86)	(0.46, 0.69)
In the last 12 months, have you ever been put off going to your GP surgery/health centre because the opening times are inconvenient?	Odds ratio	0.99	1.02	1.06	0.69	1.05	0.75
	95%	(0.84, 1.18)	(0.92, 1.13)	(0.88, 1.28)	(0.63, 0.76)	(0.92, 1.18)	(0.62, 0.91)

Respondents from BME groups were typically less positive on two out of three questions in the **safe, high quality, coordinated care** domain. With the exception of White Irish respondents, all groups were significantly less likely to say that they had confidence and trust in their doctor than White British respondents. Similarly although White Irish respondents were more favourable on this question, all other

groups except those of Mixed ethnicity were significantly less likely to report having had their medicines reviewed in the last 12 months. There were no differences between the groups on the remaining question, about whether patients referred to a specialist felt that that person had enough information about their treatment or condition. However, the lack of significant differences in this instance may be attributable to the relatively low number of respondents, since only those who had had a referral to a specialist in the last 12 months answered the question.

Table 12:   Results for 'safe, high quality, coordinated care' domain

Safe, high quality, coordinated care		White: Irish	White: Other	Mixed	Asian/Asian British	Black/black British	Chinese/ other
Did you have confidence and trust in the doctor?	Odds ratio	1.07	0.64	0.72	0.71	0.85	0.48
	95%	(0.89, 1.29)	(0.57, 0.71)	(0.59, 0.88)	(0.64, 0.78)	(0.74, 0.97)	(0.39, 0.59)
When you first saw the person you were referred to, did he/she seem to have all the necessary information about you and your condition or	Odds ratio	1.22	0.92	0.98	0.85	1.02	0.83
	95%	(0.95, 1.57)	(0.78, 1.07)	(0.72, 1.34)	(0.73, 1.01)	(0.83, 1.24)	(0.60, 1.15)
In the last 12 months, have you seen anyone at your GP surgery to check how you are getting on with this medicine?	Odds ratio	1.31	0.71	0.89	0.52	0.61	0.56
	95%	(1.02, 1.68)	(0.61, 0.83)	(0.65, 1.21)	(0.45, 0.59)	(0.51, 0.73)	(0.41, 0.78)

The **better information, more choice** and **building relationships with staff** domains showed very similar patterns of results, and so are presented and discussed together. There were no significant differences between White Irish and White British respondents on the five questions in these two domains. All other ethnic groups were significantly less likely to give favourable responses to all five questions, with the only exception being the Mixed group, who were not significantly different from the baseline on two of the items (see Tables 13 and 14).

Table 13:   Results for 'better information, more choice' domain

Better information, more choice		White: Irish	White: Other	Mixed	Asian/Asian British	Black/black British	Chinese/ other
Were you involved as much as you wanted to be in decisions about your care and treatment?	Odds ratio	0.89	0.56	0.59	0.54	0.62	0.43
	95%	(0.75, 1.05)	(0.50, 0.62)	(0.49, 0.72)	(0.49, 0.59)	(0.54, 0.70)	(0.35, 0.53)
Were you given enough information about the purpose of the medicine?	Odds ratio	1.16	0.71	0.73	0.52	0.66	0.50
	95%	(0.89, 1.51)	(0.61, 0.82)	(0.56, 0.96)	(0.46, 0.59)	(0.55, 0.78)	(0.37, 0.66)
Were you given enough information about any side-effects the medicine might have?	Odds ratio	1.04	0.76	0.81	0.60	0.69	0.52
	95%	(0.84, 1.28)	(0.66, 0.87)	(0.63, 1.05)	(0.53, 0.68)	(0.59, 0.81)	(0.39, 0.69)

Table 14:   Results for 'building relationships with staff' domain

Building relationships		White: Irish	White: Other	Mixed	Asian/Asian British	Black/black British	Chinese/ other
If you had questions to ask the doctor, did you get answers that you could understand?	Odds ratio	1.01	0.75	0.82	0.62	0.78	0.49
	95%	(0.84, 1.22)	(0.67, 0.83)	(0.66, 1.02)	(0.56, 0.69)	(0.68, 0.89)	(0.40, 0.60)
Were you given enough time to discuss your health or medical problem with the doctor?	Odds ratio	0.92	0.66	0.70	0.65	0.85	0.57
	95%	(0.77, 1.09)	(0.59, 0.73)	(0.58, 0.86)	(0.58, 0.71)	(0.74, 0.97)	(0.47, 0.71)

There was a more varied pattern of results in the **clean, comfortable, friendly place to be** domain. Whilst Asian and Chinese groups were significantly less likely to give positive responses to three of the four questions, other groups were more similar to the White British baseline. The White Irish group again showed no significant differences to any of the questions. Furthermore, people from two of the BME groups – White Other and Black – were significantly more likely to report that they were told how they long they would have to wait after arriving for an appointment at their GP practice (see Table 15).

Table 15:   Results for 'clean, comfortable, friendly place to be' domain

Clean, comfortable, friendly place to be		White: Irish	White: Other	Mixed	Asian/Asian British	Black/black British	Chinese/ other
Did someone tell you how long you would have to wait?	Odds ratio	1.23	1.31	1.23	0.94	1.32	0.84
	95%	(0.90, 1.68)	(1.09, 1.57)	(0.88, 1.73)	(0.79, 1.13)	(1.07, 1.64)	(0.58, 1.23)
In your opinion, how clean is the surgery/health centre?	Odds ratio	1.07	0.65	1.15	0.50	0.96	0.37
	95%	(0.91, 1.26)	(0.59, 0.71)	(0.95, 1.39)	(0.46, 0.55)	(0.86, 1.09)	(0.30, 0.44)
Did the doctor treat you with respect and dignity?	Odds ratio	0.95	0.68	0.65	0.50	0.75	0.34
	95%	(0.70, 1.30)	(0.58, 0.80)	(0.49, 0.85)	(0.43, 0.57)	(0.62, 0.90)	(0.26, 0.43)
When you arrived, how would you rate the courtesy of the receptionist?	Odds ratio	1.04	0.95	0.94	0.65	1.10	0.60
	95%	(0.83, 1.31)	(0.84, 1.09)	(0.74, 1.19)	(0.58, 0.72)	(0.93, 1.29)	(0.48, 0.75)

Overall, most BME groups tended to be less likely than people from the White British group to report positive experiences of their local primary health care services. This was particularly true of Asian and Chinese groups, who were each significantly less

likely to give favourable responses to thirteen of the fifteen questions tested. The White Other and Black groups also tended to give fewer positive responses, although these patterns were less consistent, with these groups being similar to or more favourable than White British respondents when asked certain questions about waiting and access to services. The Mixed group was consistently similar to or less positive than the White British group, whilst the White Irish group had a significantly greater probability of giving favourable responses to two of the questions tested.

Results are extremely similar to those observed when the analysis was last conducted using data from the 2004/05 survey, although the Mixed group appear less likely to give positive responses to a larger range of questions in the current analysis.

4.4. National Survey of community mental health service users 2007/08

The community mental health survey included service users aged 16-65 years who were registered on the Care Programme Approach (CPA). Typically, this is a group receiving long-term mental health care in a community setting. In contrast to the other surveys reported here, service users from BME groups reported very similar experiences to White British service users of the majority of questions. Where differences were observed, a similar quantity of these were in positive and negative directions, suggesting little in the way of clear overall patterns of difference in the experiences of ethnic groups when using community mental health services.

Very little difference between ethnic groups was observed in the **access and waiting** domain. Only two significant differences were detected: Asian service users were significantly less likely to say that they had received talking therapies that they wanted, whilst Black service users were significantly more likely to report that they could contact their care coordinator if they had a problem. These results are shown in Table 16.

Table 16:   Results for 'access and waiting' domain

Access and Waiting		White: Irish	White: Other	Mixed	Asian/Asian British	Black/black British	Chinese/ other
Can you contact your Care Co-ordinator if you have a problem?	Odds ratio	1.15	0.93	1.25	0.97	1.52	1.09
	95%	(0.72, 1.84)	(0.66, 1.33)	(0.83, 1.86)	(0.69, 1.35)	(1.09, 2.11)	(0.53, 2.23)
In the last 12 months, did you get the talking therapy you wanted?	Odds ratio	0.77	0.96	0.84	0.51	0.79	0.73
	95%	(0.50, 1.18)	(0.69, 1.34)	(0.56, 1.27)	(0.36, 0.73)	(0.55, 1.14)	(0.33, 1.64)

There were also few differences observed in the **safe, high quality, coordinated care** domain. For the two questions on trust and confidence in mental health professionals, no ethnic groups were significantly different from the White British baseline, with the exception of the Asian group who were more likely to report that they did have trusts and confidence in psychiatrists. Asian and Black respondents were, however, significantly less likely to have an 'out of hours' number that they could contact in a crisis, whilst Chinese respondents were more likely to say that their last two appointments had been with different psychiatrists. See Table 17 for details.

Table 17:   Results for 'safe, high quality, coordinated care' domain

Safe, high quality, coordinated care		White: Irish	White: Other	Mixed	Asian/Asian British	Black/black British	Chinese/ other
Did you have trust and confidence in the psychiatrist you saw?	Odds ratio	1.30	1.22	0.96	1.32	1.12	1.22
	95%	(0.90, 1.89)	(0.92, 1.62)	(0.70, 1.32)	(1.00, 1.72)	(0.86, 1.46)	(0.66, 2.22)
The last 2 times you had an appointment with a psychiatrist, was it...[with the same psychiatrist]?	Odds ratio	0.86	1.00	1.00	1.07	0.97	0.47
	95%	(0.58, 1.27)	(0.74, 1.36)	(0.70, 1.43)	(0.80, 1.43)	(0.73, 1.30)	(0.26, 0.84)
Did you have trust and confidence in the CPN?	Odds ratio	0.97	0.84	0.87	0.87	1.05	0.72
	95%	(0.60, 1.56)	(0.58, 1.22)	(0.57, 1.32)	(0.61, 1.26)	(0.75, 1.45)	(0.36, 1.43)
Do you have the number of someone from your local NHS Mental Health Service that you can phone out of office hours?	Odds ratio	0.90	0.95	0.80	0.61	0.66	1.55
	95%	(0.64, 1.26)	(0.72, 1.24)	(0.59, 1.09)	(0.47, 0.78)	(0.51, 0.84)	(0.83, 2.88)

In the **better information, more choice** domain, Asian service users were significantly less likely to give positive responses in two questions that asked people whether they had enough say in decisions about their care and treatment, and whether they had received information about local support groups. The only other instance where a minority group was significantly less likely to be positive in this domain was the White Irish group, who were also less likely to say that they had enough say in decisions (this was the only question in any of the four surveys where the White Irish group were observed to be significantly less positive than the White British baseline). There were no differences between ethnic groups on the two questions about whether diagnoses and the purposes of medication had been discussed with service users, but people from the White Other and Mixed groups were significantly more favourable when reporting whether they had been told about possible side effects of medication. See Table 18 for details.

Table 18:   ***Results for 'better information, more choice' domain***

Better information, more choice		White: Irish	White: Other	Mixed	Asian/Asian British	Black/black British	Chinese/ other
Do you have enough say in decisions about your care and treatment?	Odds ratio	0.70	1.05	0.97	0.77	0.95	0.56
	95%	(0.50, 0.98)	(0.82, 1.34)	(0.72, 1.30)	(0.60, 0.99)	(0.75, 1.21)	(0.31, 1.01)
In the last 12 months have you received any information about local support groups for mental health service users (e.g. MIND, Alzheimer's	Odds ratio	0.68	0.96	0.99	0.61	0.88	0.59
	95%	(0.45, 1.01)	(0.70, 1.31)	(0.69, 1.41)	(0.45, 0.83)	(0.65, 1.19)	(0.29, 1.19)
Has your diagnosis been discussed with you?	Odds ratio	0.77	0.95	0.99	0.98	1.11	0.70
	95%	(0.56, 1.07)	(0.74, 1.22)	(0.74, 1.32)	(0.77, 1.25)	(0.88, 1.40)	(0.40, 1.23)
Were the purposes of the medications explained to you?	Odds ratio	1.00	0.87	1.46	0.85	1.26	1.02
	95%	(0.59, 1.70)	(0.58, 1.30)	(0.88, 2.42)	(0.58, 1.23)	(0.82, 1.92)	(0.25, 4.24)
Were you told about possible side effects of the medications?	Odds ratio	1.25	1.52	1.62	0.98	1.25	1.85
	95%	(0.75, 2.07)	(1.02, 2.25)	(1.03, 2.55)	(0.68, 1.41)	(0.83, 1.86)	(0.48, 7.14)

The **building relationships with staff** domain showed a great deal of consistency between ethnic groups, with only one significant difference detected. Service users from the White Other group were significantly more likely to say that their psychiatrist had listened carefully to them, as shown in table nineteen. Other than that, none of the BME groups were significantly more or less likely than White British respondents to give favourable answers to any of the three questions in this domain. Results can be found in Table 19.

Table 19:   ***Results for 'building relationships with staff' domain***

Building relationships		White: Irish	White: Other	Mixed	Asian/Asian British	Black/black British	Chinese/ other
Did the psychiatrist listen carefully to you?	Odds ratio	1.15	1.41	1.10	0.99	1.15	1.06
	95%	(0.77, 1.73)	(1.03, 1.94)	(0.77, 1.55)	(0.75, 1.31)	(0.86, 1.54)	(0.56, 2.01)
Did the psychiatrist treat you with respect and dignity?	Odds ratio	1.43	1.19	1.27	1.02	0.97	0.91
	95%	(0.85, 2.40)	(0.83, 1.71)	(0.83, 1.95)	(0.74, 1.42)	(0.70, 1.34)	(0.44, 1.86)
Did the CPN listen carefully to you?	Odds ratio	0.97	1.11	0.95	0.86	1.30	0.71
	95%	(0.57, 1.64)	(0.71, 1.71)	(0.60, 1.52)	(0.58, 1.29)	(0.88, 1.90)	(0.34, 1.49)

The community mental health survey showed very few differences in the responses of people from different ethnic groups, and there was little in the way of consistent patterns within groups.

Results for this survey were relatively similar to those observed when the analysis was last undertaken, using data from the 2006/07 survey. However, two differences are worth noting. Firstly, the previous analysis showed that Black service users were more likely to report positive experiences in four areas, but of these the difference remained significant for only one item. Conversely, White Other respondents were less likely to respond positively to a number of items in the 2006/07 survey – but in the most recent survey we find that they are similar on the majority of areas and significantly more positive on two. This could be construed as a showing that ethnic differences have decreased within community mental health, but a weakness of this argument is that, in context, relatively little change has occurred.

5. Summary within each ethnic group, across settings and over time

Looking across the four different surveys, it is clear that patterns of differences between ethnic groups varied considerably. Some overall patterns do suggest themselves but these must be interpreted with caution in light of the many other differences described. Nonetheless, they provide insight into the overarching findings that emerge from the analysis.

5.1. Within each ethnic group

Responses from the **White Irish** group were generally either similar to or significantly more likely to be positive than those from the White British group.

The **Asian/Asian British** and **Chinese/Other** group were generally less likely to give positive responses compared to the White British group.

Respondents from the **White Other**, **Mixed** and **Black/Black British** groups were broadly similar to the Asian group in being frequently less positive than the baseline. However, the consistency of the differences, whilst still relatively large, was seldom as great as amongst the Asian group.

5.2. Across settings

For the **White Irish** group, differences were most apparent in the two acute sector surveys: in the inpatients survey, White Irish respondents were significantly more likely to respond favourably to 16 out of 20 tested questions, and to six out of 19 questions in the emergency departments' survey. Few differences were observed in the primary care and mental health surveys where the White Irish group's responses were near identical to the White British group.

Whilst the White Irish group were particularly likely to give positive responses in the two acute surveys, those surveys also showed striking trends of less favourable response from some other groups. This was arguably most true for the **Asian/Asian British** group, who were significantly less likely to respond positively to 12 out of 20 questions on the inpatients survey (although this group were more likely to respond positively to questions about noise at night and arrangements for discharge from hospital), and 16 out of 19 questions on the emergency departments survey. Asian respondents were also consistently less likely to give positive responses in the primary care survey, significantly on 13 out of 15 tested questions. Although they were less positive in fewer areas on the mental health survey, of all the BME groups Asian respondents were generally the most likely to report problems with the care that they had received.

The **Mixed** group, similarly, tended to be similar to or less positive than the baseline across all surveys bar the mental health survey, where little difference was observed.

An exception to these trends is that the **White Other** group was similar to or more positive than the White British baseline in the mental health survey; this was a change from 2006/07, when White Other respondents were generally less likely if anything to be favourable about their mental health care.

As in the previous analysis, patients and service users from the **Black and Black British** group showed the most varied patterns of responses across surveys. Relative to the White British group, they were likely to be less positive in the

emergency departments' and primary care surveys, but presented a mixed pattern of positive and negative results in the inpatients and mental health surveys.

5.3. Over time

Generally, the findings of this analysis appear similar to the last time the surveys were undertaken. The same general trends are apparent for all BME groups and whilst some specific results have changed there is little to suggest that these changes represent broader trends. It is arguable that the **White Irish** groups responses to the inpatients survey may be an exception to this, as, superficially, they appear to be significantly more likely to respond positively across a wider range of questions in this survey. On most of these questions, though, the results of the previous analysis were approaching significance, which suggests that the actual change has been marginal. As such, we find little evidence of any systematic changes in the patterns of responses between ethnic groups since the last set of surveys.

6. Conclusion

This analysis once again describes variations by ethnic group in patients' experience of a range of NHS services. By looking at the statistical relationships within the data it identifies areas where the reported experiences of BME groups are significantly more or less likely to be positive than those reported by patients from the White British group. Although there are a number of such areas, the ethnic differences observed do not as a whole follow consistent patterns. Whilst in some areas certain groups are markedly less likely to give positive responses, there are other aspects of care where no differences are apparent, or where results are more likely to be positive than for the White British group. Furthermore, results vary considerably across ethnic groups and across healthcare settings.

A range of factors may influence these findings, including, but not limited to, actual differences in the quality of care received, different expectations and perceptions, and different cultural norms in responding. It is also possible that geographical factors may influence the results if, for example, certain ethnic groups are clustered in particular locations. Because of the complexity of the findings, and because a very large number of tests have been conducted, readers are advised to consider overall patterns and avoid over-interpretation of the individual odds ratios and results.

Overall, the pattern of results is broadly similar to those found when this analysis was previously undertaken in May 2008. As before, results are mixed for different ethnic groups. Across settings, the fewest ethnic differences are found in the mental health survey and the most in the primary care survey, with varied results in the two acute sector surveys.

As noted above, results varied heavily across different ethnic groups. Overall, patients from the White Irish group tended to be more likely to give positive responses compared with the White British baseline, whilst those from the Asian and Chinese groups were relatively consistent in being less likely to give positive responses. The White Other and Mixed ethnicity groups were typically less positive compared with the White British baseline, but less consistently so than the Asian and Chinese groups and, indeed, they were similar to or more likely to give favourable responses than the baseline in the mental health survey. Perhaps the greatest variance was apparent in the Black/Black British group, as they were less likely to give positive responses in the PCT and A&E surveys but were often similar to or more positive than the White British respondents in the mental health and inpatients surveys.

In terms of variations across survey settings, ethnic differences were most frequent in the primary care survey, where all minority groups except the White Irish were less likely to give favourable response to a relatively large proportion of questions, and least apparent in the mental health survey, where no groups showed large-scale or consistent differences from the White British baseline. Of the two acute sector surveys, ethnic differences were considerably more varied in the inpatients survey than in the emergency departments survey.

Broadly speaking, the above patterns can be viewed as showing that people from BME groups appear more frequently to have significantly different patterns of response in areas of healthcare where the intensity of care required is relatively low, as in the primary care and emergency departments surveys. One possible explanation for this finding is that where the perceived importance of a person's contact with health services is low their responses might be more readily influenced by cultural norms or other factors that vary by ethnic groups rather than by the

standard of services. Conversely, it could be argued that there are actual differences in the standards of healthcare experienced by different ethnic groups across all services, but that these are masked because of an acquiescence effect resulting from a higher level of gratitude when the survey asks about experiences of services that are of greater or more direct importance upon peoples' health or wellbeing. Both interpretations, however, are generalisations: the 'importance' or 'intensity of care' will not always vary consistently across services as, for example, some people using primary care or emergency department services will have greater of more extensive care needs than some using inpatient or mental health services. From the data available, there is unfortunately no apparent way of testing this in more detail. Neither can we eliminate other possible explanations. For example, the lack of significant differences in the mental health survey may also reflect the responsiveness of mental health services to the needs of service users from BME groups, which has been a key policy area in recent years. Thus, a limitation of this analysis is that it does not permit us to investigate and determine precisely what the actual causes of ethnic differences across the surveys may be.

In any survey of this type, people report from their own perspective, and judge against their own expectations. The physical experiences that they have are not the only factors that influence what they say. Whilst every effort is made to minimise the effect of subjectivity – for example, by focusing on specific, reportable events rather than nebulous concepts such as satisfaction, and by cognitively testing all questions with people from a range of backgrounds – it remains inevitable that peoples' responses will to some extent be framed by their initial expectations of care. Because of this, another possible explanation for some of the differences is that there may be ethnic and cultural differences in peoples' expectations and perceptions of health services. Again, it is difficult to test this adequately. One approach in trying to evaluate this might be to look at peoples' reports of experiences that should be invariant; that is, those areas where a person's ethnicity should not feasibly have an effect on their interactions with care services. An example of this might be in questions about hospital cleanliness: within any given hospital, patients from all backgrounds should experience the same wards and departments. Some such questions showed significant differences across ethnic groups, but it is impossible to draw firm conclusions from this because the results are in fact likely to be confounded by geographical factors. If, as should be expected, certain ethnic groups are clustered in specific areas then they will not, when looking at the data in terms of national averages, have the same objective experiences as other groups: they will be treated in different hospitals, with different levels of cleanliness. The present analysis does not provide a way of separating these effects.

As this is the second time that this analysis has been undertaken, it is possible to gain some impression of how the results have changed over time. Note, however, that no statistical testing of any differences from the previous analysis has taken place, so observations may only be general rather than specific. Furthermore, as the results of the analysis are relative – they relate only to experiences of groups in comparison with the White British baseline – they cannot say anything about *absolute* changes in the experiences of people from black and minority groups: that is, reported experiences may have improved across the board without the relationships between groups changing. On the whole, however, there are relatively few large changes between the previous analysis and this one. For the most part, the same general trends are apparent, both in terms of results for groups as a whole and when looking at particular sets of questions.

Improving patients' experiences and reducing inequalities are key elements of Government healthcare policy. To provide services that are tailored to the needs of

local populations and individual patients we must examine and take into account the variations in the experiences of different groups as they interact with the full range of health services.   The national results provided in this report and in the reports produced by the Care Quality Commission provide information that helps to identify where the areas where reported experiences of healthcare services varies between groups. In some instances these differences may point to real variation in provision and delivery, whilst they could also reflect differing expectations. Either way, though, both are equally important considerations when it comes to improving the experiences of patients and service users: to ensure that high-quality patient-centred care is a reality, services must be attentive to the particular needs of their local populations and deliver services that meet their expectations.

Where differences are observed, this report does not necessarily demonstrate failings in tangible, physical aspects of service provision. It does, though, raise questions and focus attention on areas where the service, as it appears to patients and service users from particular groups, may be improved by attending to particular concerns, needs or observations. The findings reported here, along with the Care Quality Commission's reports and other data, should all be considered within the local context by NHS trusts as they seek to do this.

Annex A – Interpretation of results

This annex focuses on the results of the analysis. It provides more detail on how to interpret the figures in the tables, and provides more detail on the caveats that should be borne in mind when looking at the results.

Interpreting the odds ratios

To understand what an odds ratio is, we must first explain the term 'odds'. The odds are not shown in this report, but they are represented by a number indicating how likely it is that an individual reports a positive experience in response to a particular survey question. The analysis has been configured so that larger numbers are always more positive, so we are considering the 'odds in favour' of a positive outcome.

The aim is to understand whether the odds ratios for a particular ethnic group on a particular question are more positive or less positive than the White British comparator. We do this by calculating a number called an odds ratio. Our attention focuses on whether the odds ratio is different from 1.
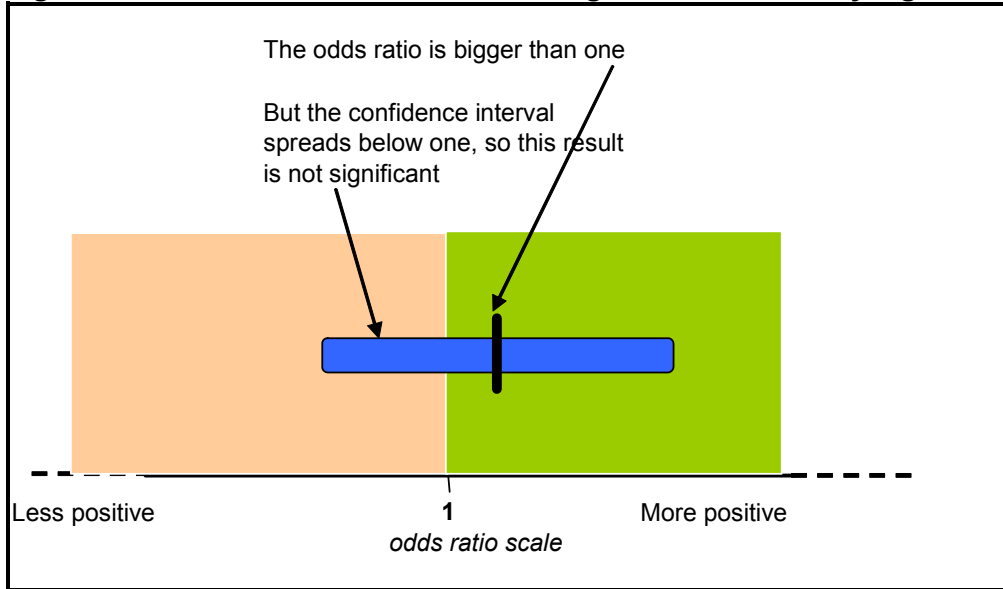
The odds ratio for the White British group is always 1, because this group is used as a baseline against which other groups are compared. If a BME group has an odds ratio greater than one, then we have some evidence that respondents in that group are more likely to give positive answers to that survey question. An odds ratio of less than one means that members of the particular group are *less* likely to give a positive answer.

If the odds ratio is quite close to 1, the difference could be because of random variation (reflecting a small number of respondents answering questions in a particular way because of their own circumstances, rather than reflecting the reports of the group as a whole). To judge whether the experience of the ethnic group is statistically different to the White British group, we need to look at the confidence interval around the odds ratio. The confidence interval is the range within which we expect the 'true' value of the odds ratio to lie. For us to be confident that a result is a 'real' difference and not merely caused by random variation – that is, for a result to be statistically significant – the range of the confidence interval must *not* cross 1: *both* the upper and lower levels shown must be either greater or less than 1.

Some examples

For example, if we look at the question "Were you involved as much as you wanted to be in decisions made about your care and treatment?" from the outpatient 2004/05 survey, the White Irish odds ratio is 1.04 and the confidence interval is 0.91 to 1.18. This shows that respondents who identified themselves as White Irish were slightly more likely to give a positive answer to this question than those who identified themselves as White British. However, the confidence interval overlaps with the value 1 (the value 1 is between 0.91 and 1.18) so we cannot be confident that this result is not simply due to random variation: the result is not statistically significant. This is illustrated in Figure 1.

Figure 1: A small difference, but not enough to be statistically significant

The odds ratio is bigger than one

But the confidence interval spreads below one, so this result is not significant

Less positive

1

More positive

odds ratio scale

On the same question the odds ratio for the Mixed ethnic group is 0.71, with a confidence interval of 0.58 to 0.87. In this case, the odds ratio is below 1 indicating that patients from Mixed BME group were less likely to give a positive answer to the question. This time, the range given by the confidence interval is entirely on one side of 1 (all the numbers are less than 1). This difference is statistically significant and it provides evidence that members of the Mixed group were less likely to give a positive response than their White British counterparts. This is illustrated in Figure 2.

Figure 2: Example of an odds ratio that is statistically significant

The odds ratio is less than one, suggesting more negative responses

and now the confidence interval is all on the same side of one. This result is significant

Less positive

1

More positive

odds ratio scale
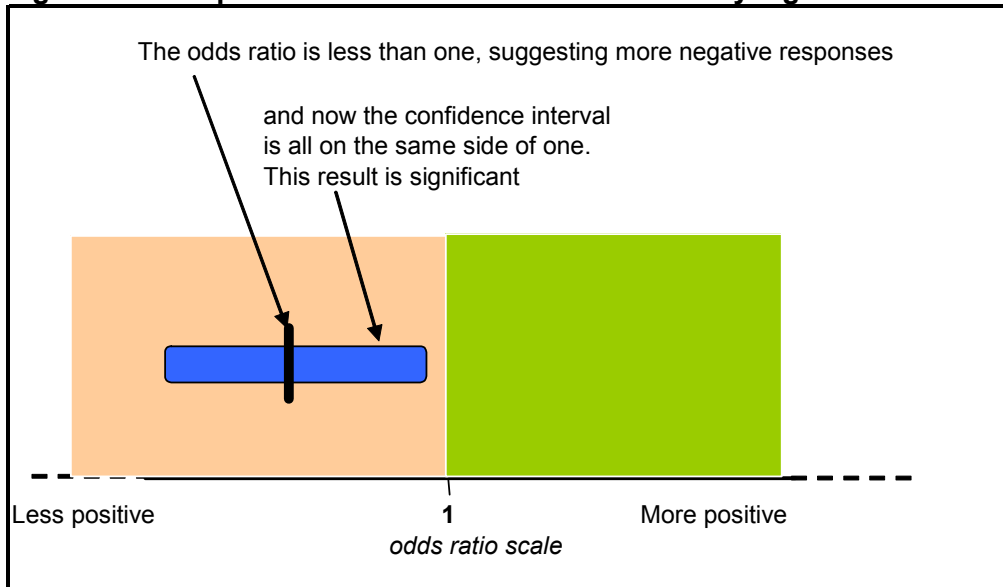
The value of the odds ratio is *not* a measure of how positive the responses were from a BME group, but a relative measure of how likely people from that group were to give positive responses compared with those of the White British group. A low odds ratio does not necessarily imply that a particular group gave very negative reports of their experience overall, but merely that they were less likely to give positive reports than the White British group.

Caveats to be noted when interpreting the results

The description above explains how to interpret one odds ratio. When interpreting the full set of results there are a number of points to be borne in mind:

- It is important to understand that this analysis has produced a large number of individual scores. When this many results are generated we would expect that some differences will show up because of chance variation. In assessing the results, it would not be sensible or appropriate to pick out extreme values. Instead, it is better to examine the overall pattern, looking at the range of 'odds ratios' across all questions, or across ethnic groups. The summary of results does this.

- The analyses are of the most recent available survey data for each setting. Some of the surveys are in different years to each other. Comparisons between surveys cannot be interpreted as changes over time. The analysis for each survey is a 'baseline' score for that setting.

- The scores, as reported, do not necessarily imply a difference in patients' treatment or that there are different standards of service for different groups. A patient's response can be influenced by a number of factors including their own expectations and perceptions. The physical situation they find themselves in is only one such factor. For instance, some people may have a higher expectation of cleanliness than others. One example from the analyses is that responses are often age-related, with older patients responding more positively than younger patients. While we have adjusted for as many of these "confounding" factors as possible, there could remain differences in subjective factors.

- Results reflect an average profile for each group and the experience of selected individuals within that group may be different.

Response rates

The response rate, that is the proportion of completed and returned surveys compared to the total number sent out, vary for different ethnic groups. Response rates are consistently lower for minority ethnic patients than they are for white groups across all five surveys for which comparisons were made.

There is a potential risk that different response rates could influence the results, for example if patients who were unhappy with their care were more likely to respond (creating a response bias). This bias tends to be larger if the response rate is lower.

The Acute Co-ordination Centre for the NHS Patient Survey Programme at the Picker Institute, working on behalf of the Care Quality Commission (then the Healthcare Commission), conducted a review of BME coverage in the patient survey programme[9]. It concluded that whole-sample estimates are unlikely to be affected. However, there is very little information that would allow us to estimate non-response bias arising specifically from the higher levels of non-response amongst minority ethnic group members of the sample. It is possible, therefore, that the results presented in this report are affected slightly by differential response rates, but we do not expect this to have a large impact on the overall pattern of results.

---

[9] The review of BME coverage in the patient survey programme is available at:
http://www.nhssurveys.org/survey/523

Annex B – Description of the analytical approach used to generate the scores

This annex provides more detail on the technical approach used in producing these results. It outlines some of the limitations imposed by the structure of the data and explains why this method of analysis was used.

Background

The surveys within the National Patient Survey Programme have large sample sizes. For example, results from the adult inpatient survey typically include responses from around 76,000 respondents. However, even with samples this large the number of responses from some of the smaller BME groups can be quite low. It is not possible to calculate reliable patient experience scores for each ethnic category, because the confidence intervals on any estimate are too large to make the results meaningful.

A brief summary of scoring methods attempted with these data.

The initial intention was to produce scores for each ethnic group, on exactly the same basis as the overall national patient experience scores. This would require us to produce age-gender standardised scores against each of five domains of care, within each of the five service settings.

We used bootstrapping techniques to assess the size of the confidence intervals on patient experience scores for ethnic groups. We explored a range of possible options for levels of standardisation and grouping of ethnic categories. Even with the age-gender standardization only, and a broad aggregation of ethnic groups (five categories), the confidence intervals were very large. It was clear that this direct approach would not produce useable scores. Some of the ethnic groups were very small and direct standardisation techniques failed, in some cases, because of empty cells or very small numbers in standardization cells.

The central problem was that there was insufficient information in the data to calculate scores on the same basis as the overall patient experience PSA scores. We used a four different approaches to simplify the data and hence to make maximum use of the available information:

a) Focussing on individual questions rather than domain scores. The surveys are structured to include a number of filter questions to guide respondents through sections that are relevant to them. This results in substantial numbers of missing values in some questions, and the missing values occur in different questions for different individuals. Grouping questions together into domains requires us either to impute missing values, or to ignore data from some respondents. Imputation leads to potentially misleading results by increasing the 'leverage' of answers from small numbers of individuals, and there are too many missing values for us to rely only on those respondents who answer all questions in a domain. Focussing on individual questions removes this problem and allows us to use all the available responses.

b) Grouping BME categories. Some of the BME categories are particularly small (the Bangladeshi group in particular has very few respondents in some surveys). Instead of relying on the full list of 16 categories, as used by ONS in the population census, we grouped responses in the standard way to 5 broad categories. As our method involved comparison with the White British group, a question arose about how we should treat other White categories. There were

sufficient data to allow us to separate White Irish and White Other, so we extended the standard list in this way.

c) Questions in the surveys are multiple choice and typically have more than two options. This provides nuanced information about the extent to which respondents agree or disagree with a particular point of view. In the standard method this is represented by applying a scoring schema for each question, in which different response options are given a different value between 0 and 100. For our analysis it is not necessary to have this degree of detail. For each question, a judgement was made as to which answers are 'positive' and which 'negative', thus converting each question into a 'positive/negative' response.

d) Calculating an absolute score for each ethnic group implies that it is possible to carry out inter-group comparisons between any pair of ethnic categories. We can reduce the amount of information required from the data if we focus instead on comparison with a single, reference, baseline group. We focussed on the White British group simply because it was by far the largest group. Confidence intervals around scores for this group are very small and it provides a 'fixed' reference group against which we can compare results for the smaller (and hence more volatile) datasets for other ethnic groups.

Description of the resulting analysis, as used in this report

Our aim is to produce an analysis that allows comparison between ethnic groups. The Care Quality Commission and the Department of Health have worked together to explore a number of different approaches to this. The results in this paper reflect the final analysis, which reduces the complexity of the data to make best use of the available 'information' within the dataset.

The survey questions are multiple choice questions, typically with 3, 4 or 5 response categories. For this analysis, the answers have been grouped into positive and negative responses. This requires a subjective judgement about which responses are positive. For example, if a patient is asked whether they have been treated with respect and dignity and they answer "yes sometimes", it is not objectively clear whether this is a positive or negative response. By default, we have treated these "yes sometimes" answers as negative, because although not the most negative option available they nonetheless represent scope for improvement. This has been modified for some questions where the distribution of responses indicated a different cut-point (for example if very few respondents had answered "yes always"). This approach converts all the response questions into binary variables.

The original data included the 16 ethnic categories used by ONS. However, for some of the minority ethnic groups, the numbers of respondents were small and it is not possible to carry out a meaningful analysis because the confidence intervals are very large. To enable us to undertake meaningful analyses of the data available, we aggregated some of the groups (see Table 19, below). This approach is practical for the analysis undertaken here, but the downside to this is we lose the ability to discern the difference between the smaller groups. For instance, the analysis presented here does not allow us to comment on different experiences between Indians and Bangladeshis, but includes them both as part of the larger Asian group.

Table 20: **Aggregating ONS ethnic groups to broader groups for analysis**

Original ONS Categories			Aggregated groups	
Value	Label		Value	Label
1	White British	→	1	White British
2	White Irish	→	2	White Irish
3	Any other White background	→	3	White Other
4	White and Black Caribbean			
5	White and Black African			
6	White and Asian			
7	Any other Mixed background		4	Mixed
8	Indian			
9	Pakistani			
10	Bangladeshi			
11	Any other Asian background		5	Asian or Asian British
12	Caribbean			
13	African			
14	Any other Black background		6	Black or Black British
15	Chinese			
16	Any other ethnic group		7	Chinese/Other

We have then fitted a model to the data using multiple logistic regression. Multiple logistic regression is a statistical technique that models the way certain factors (such as age and ethnicity) can influence the chances of a particular outcome, where there are only two possible outcomes – it happens or it does not.

The analysis attempts to discern how an individual's ethnic category affects the chances that they report a 'positive' answer to a given question. Factors other than BME grouping will also affect the response given to a question. The analyses take some of these, such as age and gender, into account. In the table below, we list the other variables that we have used in the analysis. We do not report on these other variables, but have included them to avoid differences due to other factors being mistakenly attributed to BME group.

Table 21: **Variable included in the analysis**

Variables included in the analysis	Outpatients 04/05	Primary Care 04/05	A&E 04/05	Inpatients 06/07	Mental Health 06/07
BME group	X	X	X	X	X
Age	X	X	X	X	X
Gender	X	X	X	X	X
Level of education	X	X	X	X	
Disability	X	X	X	X	
Self reported health status	X	X	X	X	X
Admission method				X	
Currently in paid work					X
Care programme approach level					X
Number of admissions in last 12 months					X
Detained during last 12 months?					X

A separate logistic regression model has been fitted for each survey question covered by the analysis. The output from the model fitting is a set of 'odds ratios' – one for each of the variables considered. These are broadly equivalent to 'co-efficients' in an ordinary logistic regression. They give an indication of the 'size' of impact that variable on the modelled outcome (positive response to the question), although in the results section of this report we are focussed only on whether the odds ratio is significantly different from 1.

The logistic regression model used is a fixed effects model for the variables listed in Table 20, above. However, the model also specifies 'Trust' as a group variable. The

specified model is, in effect, a multi-level model in which the variables above all apply at level 1 (the individual) and there is a notional level 2 (the Trust). The model does not include any trust level explanatory variables and the net effect of this specification is that the confidence intervals around the odds ratios are slightly larger than they might otherwise be. This takes account of the fact that there may be some inter-trust variation in scores (i.e. some trusts have higher or lower scores than others). We could handle this by fitting a set of indicator variables, with one indicator for each Trust, but this approach instead models the data as if the Trusts were a random sample from a notionally infinite number of trusts. This allows us to take account of inter-trust variation without using up a large number of degrees of freedom.

For each question and BME group the odds ratio and associated confidence interval has been calculated. The odds ratio for the White British group is always 1, by definition. If a BME group's odds ratio is higher than one, it indicates that a member of the particular group is more likely to give a positive answer to the question than a member of the White British group is. On the other hand, an odds ratio of less than one means that members of the particular group are *less* likely to give a positive answer.

Even if there were no systematic difference between the BME groups, we would not expect the responses to be exactly the same in our survey data. Random variations, or responses from a small number of respondents, are likely to make the value vary slightly from 1. The confidence interval allows us to judge when the difference from 1 is large enough to be interpreted as a difference attributable to the BME group, rather than natural variation. If the confidence interval does not include 1 we say that the difference is statistically significant. Details of how to interpret the odds ratio results are provided in Annex A.

It should be noted that the odds ratios are *not* a direct measure of how positive the responses were from a particular BME group, but a measure of comparison showing how likely people within a given group were to give a positive response compared with those in the White British group.

Annex C – Full tables of results

Adult inpatient 2008/09 Scores - odds ratio when compared to White British group

		White: Irish	White: Other	Mixed	Asian/Asian British	Black/black British	Chinese/ other
Access and Waiting							
Was your admission date changed by the hospital?	Odds ratio	1.14	0.88	0.68	0.74	0.71	1.02
	0.95	(0.89, 1.46)	(0.72, 1.07)	(0.48, 0.97)	(0.59, 0.93)	(0.55, 0.93)	(0.54, 1.96)
How do you feel about the length of time you were on the waiting list before your admission to hospital?	Odds ratio	1.34	0.65	0.50	0.55	0.87	0.54
	0.95	(1.05, 1.72)	(0.54, 0.78)	(0.36, 0.70)	(0.45, 0.68)	(0.67, 1.13)	(0.31, 0.94)
From the time you arrived at the hospital, did you feel that you had to wait a long time to get to a bed on a ward?	Odds ratio	1.19	0.76	0.76	0.58	0.68	0.54
	0.95	(1.02, 1.38)	(0.67, 0.85)	(0.61, 0.96)	(0.51, 0.66)	(0.58, 0.79)	(0.38, 0.76)
Safe, high quality, coordinated care							
Sometimes, a member of staff will say one thing and another will say something quite different. Did this happen to you?	Odds ratio	1.20	1.01	1.03	0.93	1.02	1.22
	0.95	(1.04, 1.38)	(0.90, 1.13)	(0.84, 1.28)	(0.82, 1.06)	(0.87, 1.19)	(0.86, 1.73)
On the day you left hospital, was your discharge delayed for any reason?	Odds ratio	1.18	1.06	1.09	1.16	1.02	1.28
	0.95	(1.03, 1.35)	(0.95, 1.19)	(0.89, 1.35)	(1.02, 1.32)	(0.88, 1.19)	(0.91, 1.80)
Did a member of staff tell you about any danger signals you should watch for after you went home?	Odds ratio	1.51	1.08	0.93	0.91	1.03	0.99
	0.95	(1.30, 1.76)	(0.95, 1.23)	(0.73, 1.17)	(0.79, 1.05)	(0.87, 1.22)	(0.67, 1.46)
Better information, more choice							
Were you involved as much as you wanted to be in decisions made about your care and treatment?	Odds ratio	1.31	0.83	0.68	0.71	0.76	0.70
	0.95	(1.15, 1.50)	(0.74, 0.92)	(0.55, 0.84)	(0.63, 0.81)	(0.66, 0.89)	(0.50, 0.97)
Did a member of staff explain the purpose of the medications you were to take at home in a way you could understand?	Odds ratio	1.35	0.94	1.14	0.86	1.17	0.93
	0.95	(1.13, 1.62)	(0.82, 1.08)	(0.87, 1.49)	(0.74, 1.00)	(0.97, 1.42)	(0.61, 1.42)
Did a member of staff tell you about medication side effects to watch for when you went home?	Odds ratio	1.96	1.15	0.98	0.89	1.19	1.45
	0.95	(1.67, 2.30)	(1.00, 1.31)	(0.77, 1.25)	(0.76, 1.03)	(1.00, 1.41)	(0.98, 2.13)
Building relationships							
When you had important questions to ask the doctor, did you get answers that you could understand?	Odds ratio	1.35	0.85	0.72	0.78	0.92	0.74
	0.95	(1.16, 1.59)	(0.75, 0.95)	(0.58, 0.90)	(0.68, 0.89)	(0.78, 1.08)	(0.53, 1.05)
Did doctors talk in front of you as if you weren't there?	Odds ratio	1.13	0.84	0.70	0.67	1.05	0.90
	0.95	(0.97, 1.31)	(0.75, 0.95)	(0.56, 0.87)	(0.59, 0.77)	(0.89, 1.24)	(0.63, 1.30)
When you had important questions to ask a nurse, did you get answers that you could understand?	Odds ratio	1.26	0.92	0.84	0.63	0.86	0.54
	0.95	(1.09, 1.47)	(0.82, 1.03)	(0.67, 1.04)	(0.55, 0.72)	(0.74, 1.01)	(0.38, 0.76)
Did nurses talk in front of you as if you weren't there?	Odds ratio	1.18	0.72	0.47	0.44	0.75	0.62
	0.95	(1.00, 1.39)	(0.64, 0.81)	(0.38, 0.59)	(0.39, 0.51)	(0.64, 0.89)	(0.44, 0.89)
Clean, comfortable, friendly place to be							
Were you ever bothered by noise at night from other patients?	Odds ratio	1.43	1.01	1.34	1.22	1.54	1.02
	0.95	(1.25, 1.65)	(0.90, 1.13)	(1.08, 1.65)	(1.07, 1.39)	(1.32, 1.80)	(0.73, 1.43)
Were you ever bothered by noise at night from hospital staff?	Odds ratio	1.44	1.12	1.18	1.50	1.87	1.78
	0.95	(1.21, 1.72)	(0.98, 1.28)	(0.92, 1.51)	(1.27, 1.77)	(1.53, 2.28)	(1.14, 2.77)
In your opinion, how clean was the hospital room or ward that you were in?	Odds ratio	1.33	0.82	0.98	0.59	0.89	0.53
	0.95	(1.16, 1.53)	(0.73, 0.91)	(0.80, 1.21)	(0.52, 0.67)	(0.77, 1.04)	(0.38, 0.75)
How would you rate the hospital food?	Odds ratio	1.10	1.00	1.07	0.97	0.92	0.70
	0.95	(0.96, 1.26)	(0.90, 1.12)	(0.86, 1.32)	(0.85, 1.11)	(0.79, 1.08)	(0.49, 0.99)
Were you given enough privacy when being examined or treated?	Odds ratio	1.18	0.87	0.83	0.87	1.22	0.56
	0.95	(0.95, 1.47)	(0.75, 1.02)	(0.63, 1.08)	(0.73, 1.03)	(0.98, 1.51)	(0.38, 0.83)
Overall, did you feel you were treated with respect and dignity while you were in the hospital?	Odds ratio	1.50	0.96	0.91	0.80	0.96	0.85
	0.95	(1.25, 1.79)	(0.84, 1.09)	(0.72, 1.15)	(0.69, 0.92)	(0.81, 1.13)	(0.59, 1.23)
Do you think the hospital staff did everything they could to help control your pain?	Odds ratio	1.29	0.88	0.88	0.72	0.97	0.64
	0.95	(1.07, 1.56)	(0.77, 1.02)	(0.69, 1.13)	(0.62, 0.84)	(0.81, 1.16)	(0.43, 0.94)

A&E 2008/09 Scores - odds ratio when compared to White British group

		White: Irish	White: Other	Mixed	Asian/Asian British	Black/black British	Chinese/ other
Access and Waiting							
From the time you first arrived at the Emergency Department, how long did you wait before being examined by a doctor or nurse practitioner?	Odds ratio	1.06	0.86	0.88	0.72	0.97	0.60
	95%	(0.87, 1.29)	(0.76, 0.96)	(0.72, 1.08)	(0.65, 0.81)	(0.84, 1.11)	(0.45, 0.79)
Overall, how long did your visit to the Emergency Department last?	Odds ratio	0.95	0.92	0.91	0.86	1.07	0.67
	95%	(0.78, 1.14)	(0.82, 1.05)	(0.74, 1.12)	(0.77, 0.97)	(0.93, 1.24)	(0.50, 0.90)
How long did you wait before you first spoke to a nurse or doctor?	Odds ratio	1.05	0.70	0.77	0.58	0.68	0.64
	95%	(0.86, 1.26)	(0.63, 0.79)	(0.63, 0.94)	(0.52, 0.64)	(0.60, 0.78)	(0.48, 0.84)
Safe, high quality, coordinated care							
Sometimes in a hospital, a member of staff will say one thing and another will say something quite different. Did this happen to you?	Odds ratio	0.98	0.82	0.90	0.63	1.06	0.57
	95%	(0.78, 1.22)	(0.72, 0.94)	(0.72, 1.12)	(0.56, 0.70)	(0.91, 1.25)	(0.42, 0.77)
Did a member of staff tell you about any danger signals regarding your illness or treatment to watch for after you went home?	Odds ratio	1.23	0.90	1.08	0.70	0.79	0.53
	95%	(0.96, 1.59)	(0.77, 1.04)	(0.84, 1.39)	(0.60, 0.82)	(0.66, 0.95)	(0.35, 0.79)
Did you have confidence and trust in the doctors and nurses examining and treating you?	Odds ratio	1.16	0.67	0.86	0.78	0.90	0.56
	95%	(0.95, 1.41)	(0.60, 0.75)	(0.71, 1.05)	(0.70, 0.87)	(0.79, 1.03)	(0.43, 0.74)
Better information, more choice							
Were you involved as much as you wanted to be in decisions about your care and treatment?	Odds ratio	1.20	0.59	0.84	0.58	0.68	0.46
	95%	(1.01, 1.44)	(0.53, 0.66)	(0.69, 1.02)	(0.52, 0.64)	(0.60, 0.78)	(0.35, 0.61)
Did a member of staff explain the purpose of the medications you were to take at home in a way you could understand?	Odds ratio	0.97	0.82	1.13	0.77	1.35	0.50
	95%	(0.62, 1.54)	(0.65, 1.03)	(0.73, 1.75)	(0.62, 0.95)	(1.00, 1.83)	(0.31, 0.81)
Did a member of staff tell you about medication side effects to watch for?	Odds ratio	1.27	1.08	1.02	1.02	0.85	0.78
	95%	(0.87, 1.86)	(0.89, 1.32)	(0.72, 1.47)	(0.84, 1.23)	(0.67, 1.09)	(0.48, 1.27)
While you were in the Emergency Department, how much information about your condition or treatment was given to you?	Odds ratio	0.97	0.78	0.80	0.85	0.82	0.66
	95%	(0.79, 1.17)	(0.69, 0.88)	(0.65, 0.98)	(0.76, 0.95)	(0.71, 0.94)	(0.49, 0.88)
Building relationships							
Did doctors or nurses talk in front of you as if you weren't there?	Odds ratio	0.99	0.48	0.48	0.38	0.72	0.40
	95%	(0.79, 1.25)	(0.42, 0.54)	(0.39, 0.59)	(0.34, 0.42)	(0.61, 0.84)	(0.30, 0.54)
Did you have enough time to discuss your health or medical problem with the doctor or nurse?	Odds ratio	1.30	0.74	0.86	0.80	1.03	0.69
	95%	(1.07, 1.57)	(0.66, 0.83)	(0.71, 1.05)	(0.72, 0.89)	(0.90, 1.18)	(0.53, 0.91)
While you were in the Emergency Department, did a doctor or nurse explain your condition and treatment in a way you could understand?	Odds ratio	1.28	0.89	0.88	0.83	0.93	0.71
	95%	(1.06, 1.54)	(0.79, 0.99)	(0.72, 1.07)	(0.75, 0.92)	(0.82, 1.06)	(0.54, 0.93)
Did the doctors and nurses listen to what you had to say?	Odds ratio	1.21	0.92	0.95	0.91	1.15	0.89
	95%	(0.99, 1.48)	(0.82, 1.04)	(0.77, 1.17)	(0.81, 1.02)	(0.99, 1.33)	(0.66, 1.20)
If you had any anxieties or fears about your condition or treatment, did a doctor or nurse discuss them with you?	Odds ratio	1.26	0.87	1.03	0.80	1.05	0.66
	95%	(1.03, 1.52)	(0.77, 0.98)	(0.83, 1.28)	(0.71, 0.89)	(0.91, 1.21)	(0.48, 0.89)
Clean, comfortable, friendly place to be							
In your opinion, how clean was the Emergency Department?	Odds ratio	1.23	0.84	1.19	0.78	1.06	0.54
	95%	(1.04, 1.45)	(0.75, 0.94)	(0.97, 1.45)	(0.69, 0.87)	(0.92, 1.21)	(0.39, 0.74)
Were you given enough privacy when being examined or treated?	Odds ratio	0.98	0.90	0.94	0.94	1.13	0.82
	95%	(0.81, 1.20)	(0.80, 1.02)	(0.76, 1.17)	(0.84, 1.06)	(0.97, 1.31)	(0.61, 1.11)
Overall, did you feel you were treated with respect and dignity while you were in the Emergency Department?	Odds ratio	1.10	0.74	0.79	0.66	0.83	0.54
	95%	(0.89, 1.36)	(0.66, 0.84)	(0.65, 0.97)	(0.59, 0.74)	(0.72, 0.95)	(0.41, 0.71)
Do you think the hospital staff did everything they could to help control your pain?	Odds ratio	1.45	0.83	0.98	0.69	0.86	0.73
	95%	(1.15, 1.83)	(0.73, 0.96)	(0.78, 1.24)	(0.61, 0.79)	(0.74, 1.01)	(0.52, 1.02)

Primary care 2007/08 Scores - odds ratio when compared to White British group

		White: Irish	White: Other	Mixed	Asian/Asian British	Black/black British	Chinese/other
Access and Waiting							
The last time you saw a doctor from your GP surgery did you have to wait for an appointment?	Odds ratio	1.07	0.89	0.96	0.75	1.22	0.64
	95%	(0.90, 1.27)	(0.79, 0.99)	(0.78, 1.19)	(0.67, 0.83)	(1.06, 1.39)	(0.50, 0.80)
How long after your appointment time did you have to wait to be seen?	Odds ratio	1.26	0.79	0.70	0.57	0.76	0.56
	95%	(1.05, 1.51)	(0.71, 0.89)	(0.58, 0.86)	(0.51, 0.62)	(0.66, 0.86)	(0.46, 0.69)
In the last 12 months, have you ever been put off going to your GP surgery/health centre because the opening times are inconvenient?	Odds ratio	0.99	1.02	1.06	0.69	1.05	0.75
	95%	(0.84, 1.18)	(0.92, 1.13)	(0.88, 1.28)	(0.63, 0.76)	(0.92, 1.18)	(0.62, 0.91)
Safe, high quality, coordinated care							
Did you have confidence and trust in the doctor?	Odds ratio	1.07	0.64	0.72	0.71	0.85	0.48
	95%	(0.89, 1.29)	(0.57, 0.71)	(0.59, 0.88)	(0.64, 0.78)	(0.74, 0.97)	(0.39, 0.59)
When you first saw the person you were referred to, did he/she seem to have all the necessary information about you and your condition or	Odds ratio	1.22	0.92	0.98	0.85	1.02	0.83
	95%	(0.95, 1.57)	(0.78, 1.07)	(0.72, 1.34)	(0.73, 1.01)	(0.83, 1.24)	(0.60, 1.15)
In the last 12 months, have you seen anyone at your GP surgery to check how you are getting on with this medicine?	Odds ratio	1.31	0.71	0.89	0.52	0.61	0.56
	95%	(1.02, 1.68)	(0.61, 0.83)	(0.65, 1.21)	(0.45, 0.59)	(0.51, 0.73)	(0.41, 0.78)
Better information, more choice							
Were you involved as much as you wanted to be in decisions about your care and treatment?	Odds ratio	0.89	0.56	0.59	0.54	0.62	0.43
	95%	(0.75, 1.05)	(0.50, 0.62)	(0.49, 0.72)	(0.49, 0.59)	(0.54, 0.70)	(0.35, 0.53)
Were you given enough information about the purpose of the medicine?	Odds ratio	1.16	0.71	0.73	0.52	0.66	0.50
	95%	(0.89, 1.51)	(0.61, 0.82)	(0.56, 0.96)	(0.46, 0.59)	(0.55, 0.78)	(0.37, 0.66)
Were you given enough information about any side-effects the medicine might have?	Odds ratio	1.04	0.76	0.81	0.60	0.69	0.52
	95%	(0.84, 1.28)	(0.66, 0.87)	(0.63, 1.05)	(0.53, 0.68)	(0.59, 0.81)	(0.39, 0.69)
Building relationships							
If you had questions to ask the doctor, did you get answers that you could understand?	Odds ratio	1.01	0.75	0.82	0.62	0.78	0.49
	95%	(0.84, 1.22)	(0.67, 0.83)	(0.66, 1.02)	(0.56, 0.69)	(0.68, 0.89)	(0.40, 0.60)
Were you given enough time to discuss your health or medical problem with the doctor?	Odds ratio	0.92	0.66	0.70	0.65	0.85	0.57
	95%	(0.77, 1.09)	(0.59, 0.73)	(0.58, 0.86)	(0.58, 0.71)	(0.74, 0.97)	(0.47, 0.71)
Clean, comfortable, friendly place to be							
Did someone tell you how long you would have to wait?	Odds ratio	1.23	1.31	1.23	0.94	1.32	0.84
	95%	(0.90, 1.68)	(1.09, 1.57)	(0.88, 1.73)	(0.79, 1.13)	(1.07, 1.64)	(0.58, 1.23)
In your opinion, how clean is the surgery/health centre?	Odds ratio	1.07	0.65	1.15	0.50	0.96	0.37
	95%	(0.91, 1.26)	(0.59, 0.71)	(0.95, 1.39)	(0.46, 0.55)	(0.86, 1.09)	(0.30, 0.44)
Did the doctor treat you with respect and dignity?	Odds ratio	0.95	0.68	0.65	0.50	0.75	0.34
	95%	(0.70, 1.30)	(0.58, 0.80)	(0.49, 0.85)	(0.43, 0.57)	(0.62, 0.90)	(0.26, 0.43)
When you arrived, how would you rate the courtesy of the receptionist?	Odds ratio	1.04	0.95	0.94	0.65	1.10	0.60
	95%	(0.83, 1.31)	(0.84, 1.09)	(0.74, 1.19)	(0.58, 0.72)	(0.93, 1.29)	(0.48, 0.75)

Community mental health 2007/08 Scores - odds ratio when compared to White British group

		White: Irish	White: Other	Mixed	Asian/Asian British	Black/black British	Chinese/ other
Access and Waiting							
Can you contact your Care Co-ordinator if you have a problem?	Odds ratio	1.15	0.93	1.25	0.97	1.52	1.09
	95%	(0.72, 1.84)	(0.66, 1.33)	(0.83, 1.86)	(0.69, 1.35)	(1.09, 2.11)	(0.53, 2.23)
In the last 12 months, did you get the talking therapy you wanted?	Odds ratio	0.77	0.96	0.84	0.51	0.79	0.73
	95%	(0.50, 1.18)	(0.69, 1.34)	(0.56, 1.27)	(0.36, 0.73)	(0.55, 1.14)	(0.33, 1.64)
Safe, high quality, coordinated care							
Did you have trust and confidence in the psychiatrist you saw?	Odds ratio	1.30	1.22	0.96	1.32	1.12	1.22
	95%	(0.90, 1.89)	(0.92, 1.62)	(0.70, 1.32)	(1.00, 1.72)	(0.86, 1.46)	(0.66, 2.22)
The last 2 times you had an appointment with a psychiatrist, was it…[with the same psychiatrist]?	Odds ratio	0.86	1.00	1.00	1.07	0.97	0.47
	95%	(0.58, 1.27)	(0.74, 1.36)	(0.70, 1.43)	(0.80, 1.43)	(0.73, 1.30)	(0.26, 0.84)
Did you have trust and confidence in the CPN?	Odds ratio	0.97	0.84	0.87	0.87	1.05	0.72
	95%	(0.60, 1.56)	(0.58, 1.22)	(0.57, 1.32)	(0.61, 1.26)	(0.75, 1.45)	(0.36, 1.43)
Do you have the number of someone from your local NHS Mental Health Service that you can phone out of office hours?	Odds ratio	0.90	0.95	0.80	0.61	0.66	1.55
	95%	(0.64, 1.26)	(0.72, 1.24)	(0.59, 1.09)	(0.47, 0.78)	(0.51, 0.84)	(0.83, 2.88)
Better information, more choice							
Do you have enough say in decisions about your care and treatment?	Odds ratio	0.70	1.05	0.97	0.77	0.95	0.56
	95%	(0.50, 0.98)	(0.82, 1.34)	(0.72, 1.30)	(0.60, 0.99)	(0.75, 1.21)	(0.31, 1.01)
In the last 12 months have you received any information about local support groups for mental health service users (e.g. MIND, Alzheimer's	Odds ratio	0.68	0.96	0.99	0.61	0.88	0.59
	95%	(0.45, 1.01)	(0.70, 1.31)	(0.69, 1.41)	(0.45, 0.83)	(0.65, 1.19)	(0.29, 1.19)
Has your diagnosis been discussed with you?	Odds ratio	0.77	0.95	0.99	0.98	1.11	0.70
	95%	(0.56, 1.07)	(0.74, 1.22)	(0.74, 1.32)	(0.77, 1.25)	(0.88, 1.40)	(0.40, 1.23)
Were the purposes of the medications explained to you?	Odds ratio	1.00	0.87	1.46	0.85	1.26	1.02
	95%	(0.59, 1.70)	(0.58, 1.30)	(0.88, 2.42)	(0.58, 1.23)	(0.82, 1.92)	(0.25, 4.24)
Were you told about possible side effects of the medications?	Odds ratio	1.25	1.52	1.62	0.98	1.25	1.85
	95%	(0.75, 2.07)	(1.02, 2.25)	(1.03, 2.55)	(0.68, 1.41)	(0.83, 1.86)	(0.48, 7.14)
Building relationships							
Did the psychiatrist listen carefully to you?	Odds ratio	1.15	1.41	1.10	0.99	1.15	1.06
	95%	(0.77, 1.73)	(1.03, 1.94)	(0.77, 1.55)	(0.75, 1.31)	(0.86, 1.54)	(0.56, 2.01)
Did the psychiatrist treat you with respect and dignity?	Odds ratio	1.43	1.19	1.27	1.02	0.97	0.91
	95%	(0.85, 2.40)	(0.83, 1.71)	(0.83, 1.95)	(0.74, 1.42)	(0.70, 1.34)	(0.44, 1.86)
Did the CPN listen carefully to you?	Odds ratio	0.97	1.11	0.95	0.86	1.30	0.71
	95%	(0.57, 1.64)	(0.71, 1.71)	(0.60, 1.52)	(0.58, 1.29)	(0.88, 1.90)	(0.34, 1.49)