

[Name and address of GP practice]

February 2013

Dear Patient,

**The PRISMATIC study. Predicting people's risk of needing
emergency hospital treatment**

I am writing to ask for your help with a study about health services in Wales.

A team from the College of Medicine, Swansea University is studying the effect of a new scoring system (Prism) which is being introduced in GP practices in Wales. The system provides GPs with a score which predicts people's risk of needing emergency hospital treatment in the following year. The study aims to find out whether GPs and other health professionals use the system and how it affects the way people are treated and cared for.

Our practice is taking part in the study known as PRISMATIC. Your name has been selected at random from our patient list. As part of the study we would like to send you up to three questionnaires for this study. We hope the findings will help improve health services.

An information sheet is enclosed with more information. Please read this and if you are willing to take part, please complete the consent form and questionnaire and return them to the research team at Swansea University in the FREEPOST envelope provided.

This letter has come from your GP practice. **Your details have not been seen by the research team and they will not be given your name unless you agree to take part.** If you would like further information please visit the study website www.trustresearch.org.uk/prismatic or contact the research team at Swansea University on 01792 602346.

Thank you very much for your help, and we hope you will support this research.

Yours sincerely,

[name of lead Prism GP]

Encl: Information Sheet
Consent form
Pre paid envelope
Questionnaire



Draft

Study Number:



QUESTIONNAIRE

CONFIDENTIAL

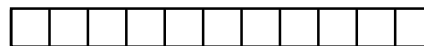
Version 2.3

PLEASE READ THESE INSTRUCTIONS CAREFULLY

- ▶ Please read the accompanying Participant Information Sheet (v5)
- ▶ Please use a blue or black pen, not a pencil
- ▶ Please mark your answers with an X clearly inside the box, unless otherwise stated, e.g.
- ▶ Please answer every question, if you find it hard to answer a question, do the best you can
- ▶ If you find the questionnaire difficult to complete, you can ask someone to help to complete it on your behalf
- ▶ Please return the completed questionnaire in the FREEPOST envelope provided
- ▶ If you have any questions about the PRISMATIC study, please contact us on 01792 602346 or email prismatic@swansea.ac.uk

THANK YOU

www.trustresearch.org.uk/prismatic



x1: Date of questionnaire completion d d m m y y y y
 / / 2 0

x2: Are you completing this survey on behalf of someone else?

Yes ➔ Go to question x3

No ➔ Go to Section A

x3: If yes, which of the following best describes your relationship to the questionnaire recipient?

- Family member
- Friend/neighbour
- Health/social care professional
- Other

SECTION A: General Health

This survey asks for your views about your health. This information will help keep track of how you feel and how well you are able to do your usual activities.

A1. In general, would you say your health is:

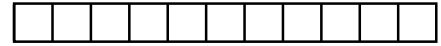
Excellent Very Good Good Fair Poor

The following questions are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

	Yes, limited a lot	Yes, limited a little	No, not limited at all
A2. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A3. Climbing several flights of stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



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During the past 4 weeks, how much of the time have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

		All of the time	Most of the time	Some of the time	A little of the time	None of the time
A4.	Accomplished less than you would like	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A5.	Were limited in the kind of work or other activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

During the past 4 weeks, how much of the time have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

		All of the time	Most of the time	Some of the time	A little of the time	None of the time
A6.	Accomplished less than you would like	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A7.	Did work or activities less carefully than usual	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A8.	During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?					
	Not at all <input type="checkbox"/>	A little bit <input type="checkbox"/>	Moderately <input type="checkbox"/>	Quite a bit <input type="checkbox"/>	Extremely <input type="checkbox"/>	

These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling.

How much of the time, during the past 4 weeks -

		All of the time	Most of the time	Some of the time	A little of the time	None of the time
A9	Have you felt calm and peaceful?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A10	Did you have a lot of energy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A11	Have you felt downhearted and depressed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



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A12. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting friends, relatives, etc.)?

All of the Time

Most of the Time

Some of the Time

A Little of the Time

None of the Time

SECTION B: Service Use

This section asks about health and social care services used **in the last 9 months**.

B1: Have you visited any hospital in relation to your own health (i.e. as a patient)?

Yes → Go to question B2

No → Go to question B5

B2: Have you attended Accident and Emergency (A&E) in relation to your own health?

Yes → Go to question B2a

No → Go to question B3

B2a: If yes, how many times have you attended A&E in relation to your own health?

Please write in an estimate of the number of separate visits. No. of A&E visits

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B2b: How many of these A&E visits resulted in an admission to hospital immediately after your A&E visit - i.e. an emergency admission?

No. of emergency admissions

Please write in an estimate of the number of separate admissions

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B3: Have you stayed in hospital overnight (i.e. as an inpatient)?

Yes → Go to question B3a

No → Go to question B4

B3a: If yes, how many nights have you stayed in hospital?

Please write in an estimate of the number of nights you have spent in hospital

No. of nights

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□ □ □ □ □ □ □ □ □ □

This section continues to ask about health and social care services used **in the last 9 months**.

B4: Have you had a hospital outpatient or day surgery appointment?

Yes → Go to question B4a No → Go to question B5

B4a: If yes, how many outpatient/day surgery appointments have you had?

Please write in an estimate of the number of appointments. No. of OP/day surgery appointments

□ □

B5: Have you attended hospital day care in relation to your own care?

(Examples of hospital day care in the area include Cam Cyntaf (First Steps) Day Centre at Glan Rhyd, the elderly day unit at NPT hospital, Y Bwthyn Newydd at Princess of Wales Hospital, and Y Rhosyn, the cancer and supportive palliative day care unit at NPT Hospital).

Yes → Go to question B5a No → Go to question B6

B5a: If yes, how many separate day care visits have you made?

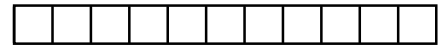
Please write in an estimate of the number of visits No. of day care visits

□ □

B6: Please provide details of the GP services that you have used in **relation to your own care**.

For each service please cross the appropriate box for used or not used. For those you have used please write in the approximate number of times you have used the service.

Service	Used		→	Approximate number of contacts, visits or appointments
	No <input type="checkbox"/>	Yes <input type="checkbox"/>		□ □
a) GP consultation - in person	No <input type="checkbox"/>	Yes <input type="checkbox"/>	→	□ □
b) GP consultation - by telephone	No <input type="checkbox"/>	Yes <input type="checkbox"/>	→	□ □
c) GP consultation - home visit	No <input type="checkbox"/>	Yes <input type="checkbox"/>	→	□ □
d) Practice nurse appointment	No <input type="checkbox"/>	Yes <input type="checkbox"/>	→	□ □
e) Clinic provided in GP practice (e.g. diabetes, asthma, ante-natal)	No <input type="checkbox"/>	Yes <input type="checkbox"/>	→	□ □
f) GP Out of Hours Service	No <input type="checkbox"/>	Yes <input type="checkbox"/>	→	□ □



B7: Please provide details of other services that you have used in relation to your own care.

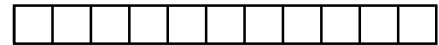
For each service please cross the appropriate box for used or not used. For those you have used please write in the approximate number of times you have used the service.

Service	Used		Approximate number of contacts, visits or appointments
a) NHS Direct	No <input type="checkbox"/>	Yes <input type="checkbox"/>	➔ <input type="text"/> <input type="text"/>
b) District Nurse	No <input type="checkbox"/>	Yes <input type="checkbox"/>	➔ <input type="text"/> <input type="text"/>
c) Health Visitor	No <input type="checkbox"/>	Yes <input type="checkbox"/>	➔ <input type="text"/> <input type="text"/>
d) Counsellor	No <input type="checkbox"/>	Yes <input type="checkbox"/>	➔ <input type="text"/> <input type="text"/>
e) Community Nurse / case manager (e.g. respiratory, mental health, chronic conditions)	No <input type="checkbox"/>	Yes <input type="checkbox"/>	➔ <input type="text"/> <input type="text"/>
f) Physiotherapist	No <input type="checkbox"/>	Yes <input type="checkbox"/>	➔ <input type="text"/> <input type="text"/>
g) Psychologist	No <input type="checkbox"/>	Yes <input type="checkbox"/>	➔ <input type="text"/> <input type="text"/>
h) Occupational therapist	No <input type="checkbox"/>	Yes <input type="checkbox"/>	➔ <input type="text"/> <input type="text"/>
i) Speech therapist	No <input type="checkbox"/>	Yes <input type="checkbox"/>	➔ <input type="text"/> <input type="text"/>
j) Other therapist	No <input type="checkbox"/>	Yes <input type="checkbox"/>	➔ <input type="text"/> <input type="text"/>
k) Alternative medicine provider e.g. acupuncturist, herbalist, reflexologist	No <input type="checkbox"/>	Yes <input type="checkbox"/>	➔ <input type="text"/> <input type="text"/>

B8: Please provide details of any of the following additional services that you have used in relation to your own care.

For each service please cross the appropriate box for used or not used. For those you have used write in the approximate number of times you have used the service.

Service	Used		Approximate number of contacts, visits or appointments
a) Home help/home care worker	No <input type="checkbox"/>	Yes <input type="checkbox"/>	➔ <input type="text"/> <input type="text"/>
b) Community support worker	No <input type="checkbox"/>	Yes <input type="checkbox"/>	➔ <input type="text"/> <input type="text"/>
c) Social worker	No <input type="checkbox"/>	Yes <input type="checkbox"/>	➔ <input type="text"/> <input type="text"/>
d) Self help/support group/luncheon club	No <input type="checkbox"/>	Yes <input type="checkbox"/>	➔ <input type="text"/> <input type="text"/>
e) Day care (non hospital based)	No <input type="checkbox"/>	Yes <input type="checkbox"/>	➔ <input type="text"/> <input type="text"/>



SECTION C: Quality of Care

C1: How would you rate the overall care you have received from NHS services over the last 9 months?

- Very Poor
- Poor
- Fair
- Good
- Excellent

C2: When did you last have an appointment to see or speak with a GP from your registered GP surgery in relation to your own care?

- Within the last 9 months ➡ Go to question C3
- Longer than 9 months ago or never ➡ Questionnaire End - thank you

C3: What type of appointment did you have?

- Appointment to see a GP at the surgery
- Appointment to speak to a GP on the phone
- Appointment for a GP to visit me in my home

C4: How serious do you feel the medical condition/issue that you presented was?

- Extremely serious
- Very serious
- Moderately serious
- Slightly serious
- Not serious

C5: How would you rate the following factors about your most recent GP surgery visit?

	Very dissatisfied	Dissatisfied	Neutral	Satisfied	Very satisfied
a) Waiting time for an appointment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Helpfulness of reception staff	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Time spent with the GP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Extent you felt the GP was concerned about you as a person	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Answers to your questions from your GP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) Advice to support your management of your condition/illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) Outcome of your medical treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h) Overall quality of care from your GP surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



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SECTION D: About you
All information is confidential

D1: Gender?

Male Female

D2: What is your date of birth? d d m m y y y y
 / /

D3: What is your postcode? /

Thank you for completing this questionnaire.
Please return in the FREEPOST envelope provided