***[Logo]***

***Name and address of homecare provider***

**Have your say to improve your Homecare Service**

Enclosed is a questionnaire about your satisfaction with the homecare services you receive from *[insert homecare provider name]*. We are seeking your feedback to monitor service performance and help identify potential service improvements on behalf of both your referring hospital and *[insert homecare provider name]*. The results will be shared with your referring hospital.

This questionnaire is not for managing your individual care and we are unable to follow up on individual points raised. If you would like to discuss any concerns about the service or treatment you receive, please contact your hospital or our customer services team in the usual way.

We do not ask for your name or any details which would identify you. However, if you do give information which identifies you, in some circumstances, relating to your safety and/or treatment effectiveness, we may need to contact you. By providing any details which would identify you, you are giving your consent for your information to be used for the purpose outlined above.

If you are the Parent / Guardian of a child or a carer of someone who may have difficulty completing this questionnaire, we would be grateful if you would assist them in filling out the questionnaire about their homecare service.

Please return your completed questionnaire in the envelope provided, at your earliest convenience.

Should you need help to complete the questionnaire, please contact us on [Homecare Provider contact details]

Thank you.

[Signature – Homecare Provider]

**Have your say to improve your Homecare Service**

Are you: the patient Other (e.g. carer/family member)

**Thinking about your homecare service**

**Overall, how was your experience of our service?**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Very good | Good | Neither good nor poor | Poor | Very Poor | Don’t know |
|  |  |  |  |  |  |

**Some detailed questions about parts of the homecare service**

**Customer Services**

|  |  |
| --- | --- |
|  | Please tick (✓) |
| **How satisfied are you with:** | Extremely dissatisfied | Fairly dissatisfied | Neither satisfied or dissatisfied | Fairly satisfied | Extremely satisfied | Not applicable |
| the way your services are arranged and information provided |  |  |  |  |  |  |
| the ease of contacting your customer service team |  |  |  |  |  |  |
| the way any queries are answered or any problems are sorted out |  |  |  |  |  |  |
| the way any complaints or concerns are handled |  |  |  |  |  |  |
| the helpfulness and courtesy of the customer service team |  |  |  |  |  |  |
| the overall quality of the customer service team |  |  |  |  |  |  |

**Delivery**

|  |  |
| --- | --- |
|  | Please tick (✓) |
| **How satisfied are you with:** | Extremely dissatisfied | Fairly dissatisfied | Neither satisfied or dissatisfied | Fairly satisfied | Extremely satisfied | Not applicable |
| the choice of delivery time that was offered to you |  |  |  |  |  |  |
| the punctuality of your deliveries |  |  |  |  |  |  |
| the accuracy and completeness of supplies delivered |  |  |  |  |  |  |
| the helpfulness and courtesy of the person making the delivery |  |  |  |  |  |  |
| the collection of waste/unused equipment |  |  |  |  |  |  |
| the overall quality of the delivery service |  |  |  |  |  |  |

**Nursing / Clinical Support Services**

*Only complete this section if the homecare nurse, or other healthcare professional, visits you at home or otherwise supports you as part of your homecare service. This could be face to face or remotely via a telephone patient support service, video call, internet or mobile phone app. If you don’t have a nursing / clinical support service please move on to the next question.*

|  |  |
| --- | --- |
|  | Please tick (✓) |
| **How satisfied are you with:** | Extremely dissatisfied | Fairly dissatisfied | Neither satisfied or dissatisfied | Fairly satisfied | Extremely satisfied | Not applicable |
| the timeliness of arrival or contact (e.g. telephone call) |  |  |  |  |  |  |
| the professionalism and politeness of clinical staff |  |  |  |  |  |  |
| the confidence in the quality of support and advice you receive |  |  |  |  |  |  |
| the overall quality of our nursing and clinical support services you receive |  |  |  |  |  |  |

Was your nursing / clinical support service was delivered remotely or face-to-face?

|  |  |  |  |
| --- | --- | --- | --- |
| Remotely  | Face to Face | Both | Don’t know |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

What sort of appointments would you be happy to have in the future? Tick all that apply.

|  |  |  |
| --- | --- | --- |
| Face to Face | Telephone | Video |
|  |  |  |

**Hospital Management of Homecare Medicine Services**

|  |  |
| --- | --- |
|  | Please tick (✓) |
| **How satisfied are you with:** | Extremely dissatisfied | Fairly dissatisfied | Neither satisfied or dissatisfied | Fairly satisfied | Extremely satisfied | Not applicable |
| the information your hospital provided about your therapy and the prescribed medication. |  |  |  |  |  |  |
| the information your hospital provided about the available homecare service. |  |  |  |  |  |  |
| the information provided about who can be contacted in your hospital if you have a query or concern |  |  |  |  |  |  |
| the way any complaints or concerns are handled by your hospital |  |  |  |  |  |  |

**[Insert any homecare provider specific questions]**

**About your homecare service**

Hospital Name

Department / Clinic Name

Homecare Medicine / Therapy Name

How long have you been receiving your current Homecare Service?

Less than 1 year 1-2 years 2-5 years 5-10 years over 10 years

**Your review and suggestions for your homecare service**

Give your opinion in your own words. The more detail you can give, the more useful your review will be. Do not write any personal details in this box.

We would like to use your anonymised comments in materials or reports.

 Please tick this box if you are happy for your comments to be used in this way.

Comments containing the following will not be published, or will be edited:

* Names of individuals, mention of gender, or identifying features.
* Offensive, abusive, or inappropriate language or remarks.
* Complaints relating to clinical negligence which should first be addressed to the relevant hospital or clinic

**Thank you for taking the time to review your homecare service**