

## Neurological Health Service Experience Survey

We want to know what you thought of your **most recent encounter** with your local NHS health service about your neurological condition. This could be, for example, an appointment with your Neurologist, doctor at the outpatients' clinic, a Specialist Nurse or with a Physiotherapist or Speech and Language Therapist. **This does not include an appointment with your GP.**

**This appointment must have happened within the last 12 months.**

The responses you give will help to improve your local **adult** NHS Neurology services. **The Neurological Alliance of Scotland is an independent umbrella organisation of charities and groups representing people with neurological conditions. Your individual responses will be completely confidential and will not be shared with the health professionals who look after you.**

### Instructions

The questions should be answered by the person who attended the health service. A friend or carer can help you complete the survey but the answers should be yours not theirs.

The survey is easy to answer and takes approximately 15 minutes to complete. Please answer all questions. For each question, please place a tick in the box next to the answer that most closely matches your own experience. For example, if your answer is yes, write in a tick as below:

- Yes  
 No

Don't worry if you make a mistake. Simply cross it out and tick the correct answer.

## About You

**1. The person completing this survey is:**

The Patient  friend, relative or carer

**2. Do you have any of the following?**

Multiple Sclerosis  Parkinson's Disease  Motor Neurone Disease

Epilepsy  Headache  Huntington's Disease

PSP  Transverse Myelitis  Spina Bifida/Hydrocephalus

Ataxia  Muscular Dystrophy  ME/CFS

Other (please state)

**3. How long have you had your neurological condition?**

**4. Are you male or female?**

Male  Female

**5. What was your age on your last birthday?**

*Please answer in full years only*

## About Your Last Appointment

6. Please state when your last appointment was:

7. Please state where your last appointment was:

Name of hospital/clinic

Name of Town/City

8. Who was your last appointment with?

Neurologist  Condition Specialist Nurse

General Nurse  Care of the Elderly Physician

Physiotherapist  Dietician

Occupational Therapist  Speech & Language Therapist

Neuropsychiatrist  Neuropsychologist

Other (please state)

9. How long after the stated appointment time did the appointment start?

Seen on time or early  Waited up to 30 minutes

Waited 31 – 60 minutes  Waited more than 1 hour

Waited more than 2 hours  Don't know/Can't remember

10. If you waited longer than 30 minutes, did you receive an explanation for the delay?

Yes, I did  No, but would have liked an explanation

No, but I did not mind  Don't know/Can't remember

## About Your Consultation

### 11. Think of the person with whom you had your last appointment. How much do you agree or disagree with the following?

Please tick **ONE** box on each line

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Not relevant	Don't know/ Can't recall
The person really listened to me	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
The person fully understood my concerns	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
The person explained things clearly	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
The person made a plan of action with me	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
The person discussed what was most important to me in managing my own health	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
The person involved me as much as I wanted in decisions about my care and/or treatment	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
The person considered and addressed my specific needs	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7

## About Living With Your Condition

- 12. How much do you agree or disagree with each of the following about any medication you were given? (If you didn't get any medicines go to Question 13)**

Please tick **ONE** box on each line

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Not relevant	Don't know/ Can't recall
I understood what my medicines were for	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
I understood how and when to take my medicines	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
I understood the possible side effects and what to do if I had any concerns	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7

- 13. Think about the support you've received to help live with your condition. How much do you agree or disagree with the following?**

Please tick **ONE** box on each line

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Not relevant	Don't know/ Can't recall
I have been given the right amount of information (verbal and written) about my condition	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Not relevant	Don't know/ Can't recall
The quality of information I have been given is good	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
Information about my condition was also given to my family and/or carer	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
I have had enough support from my health and social care team to help manage my health	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
The support and care I have received is joined up and is working for me	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
I have been given information about voluntary organisations and support groups	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
I have been told who to contact if my symptoms or condition gets worse	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7

## About Your Overall Experience

**14 How would you rate your last encounter, overall?**

Excellent  Good  Fair  Poor  Very Poor

**15 Do you have any further comments about your experience of neurological health services?**

*Please state in the box below.*

**Thank you for taking the time to complete this survey**

Please return this survey to us by **Friday 14<sup>th</sup> October 2011** in the envelope provided to:

**Freepost RSSS-KEGT-ZACT  
The Neurological Alliance of Scotland  
Mansfield Traquair Centre  
15 Mansfield Place  
Edinburgh EH3 6BB**

**If you prefer you can complete this survey online at**

**<http://www.surveymonkey.com/s/scotneuroalliancehealth1>**

**For more information about the Neurological Alliance of Scotland, please visit our website at [www.scottishneurological.org.uk](http://www.scottishneurological.org.uk)**