**Patient Transport Service patient survey**

We are undertaking a review of our Patient Transport Service. We ask that you complete this survey on your **recent journey** to identify the strengths and weakness in our service. By letting us know what is important to you your opinions will influence improvements to your service.

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| **Which hospital and department did you attend?** |
|  |
|  |
| **Why did you need to use patient transport?** |
|  | Medical need |  | Poor public transport |  | Mobility problems |
|  | Distance from treatment centre | Other, please specify… |
|  |
| **If you had not travelled by patient transport, how would you have travelled to hospital?** |
|  | Public transport  |  | Own transport  |  | Taxi |
|  | Relative/Friend/Carer |  | I would not have attended appointment  |
|  |
| **How long did you wait to be picked up?**  |
|  | 0-30 minutes  |  | 31-60 minutes  |  | 61-90 minutes  |  | Over 90 minutes  |
|  |
| **Did the patient transport allow you to arrive in time for your appointment?**  |
|  | Yes |  | No  |
|  |
| **After your appointment, how long did you wait before transport arrived to take you home?**  |
|  | 0-15 minutes  |  | 16-30 minutes  |  | 31-60 minutes  |  | More than 1 hour  |
|  |
| **Did you have someone to accompany you on the journey?** |
|  | Yes |  | No  |
| If yes, please give the reasons for this |
|  |
| **How would you rate the following aspects of your experience?** |
|  | **Very good** | **Good** | **OK** | **Poor** | **Very poor** |
| **Booking process** |  |  |  |  |  |
| **Comfort of your journey** |  |  |  |  |  |
| **Waiting times** |  |  |  |  |  |
| **Communication** |  |  |  |  |  |
|  |
| **Did the vehicle carry patient complaints and appreciation leaflets?** |
|  | Yes  |  | No |
|  |
| **What was good about your most recent patient transport journey?** |
|  |
| **What could have been better about your most recent patient transport journey?** |
|  |
|  |
| **What is important to you about a patient transport service?** |
|  |

Please return this survey to

**FREEPOST NHS South Yorkshire**

Or complete online at [www.bit.ly/SYpatienttransport](http://www.bit.ly/SYpatienttransport)

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| **Equality monitoring - OPTIONAL** |
| We need to gather the following information so we know how this proposal might affect different communities. All information will be protected and stored securely in line with data protection rules. You don’t have to answer these questions, but we would be very grateful if you would. |
|  |
| **Please tell us the first part of your postcode** (e.g. DN2, S60) |
| Please enter here  |  |  | Prefer not to say  |
|  |
| **What is your sex?** |
|  | Female  |  | Male |  | Prefer not to say  |
|  |
| **Gender reassignment** |
| Have you gone through any part of a process to change from the sex you were described as at birth, or do you intend to? (For example, how you present yourself, taking hormones, changing your name, or having surgery?) |
|  | Yes  |  | No  |  | Prefer not to say  |
|  |
| **What is your age?** |
|  | years |  |  | Prefer not to say |
|  |
| **What is your sexual orientation?** |
|  | Bisexual |  | Heterosexual |  | Homosexual  |
|  | Other, please specify |  |  | Prefer not to say |
|  |
| **What is your ethnic background?** |
| **Asian, or Asian British** | **Black, or Black British** | **Mixed / multiple ethnic group** | **White** | **Other** |
|  | Chinese  |  | African |  | Asian & White |  | British |  | Arab |
|  | Indian |  | Caribbean |  | Black African & White |  | Gypsy/Traveller |   |
|  | Pakistani |  |  |   |  |   |
|  | Other Asian background |  | Other Black background |  | Other Mixed / multiple ethnic background |  | Other White background |
|  | Other, please specify |  |  | Prefer not to say |
|  |
| **Do you consider yourself to belong to any religion?** |
|  | Buddhism |  | Christianity |  | Hinduism |
|  | Islam |  | Judaism |  | Sikhism |
|  | No religion |  | Other, please specify |  |  | Prefer not to say |
|  |
| **Do you live with any of these conditions?** (Tick all that apply) |
|  | Autism |  | Learning disability |  | Mental Health condition |
|  | Limitations to physical mobility |  | Hearing impairment or Deaf |  | Visual impairment or Blind |
|  | Long-standing health condition or illness |  | Prefer not to say |
|  | Other, please specify |
|  |
| **Do you provide care for someone?** |
| Such as family, friends, neighbours or others who are ill, disabled or who need support because they are older. |
|  | Yes  |  | No  |  | Prefer not to say  |