



Ipsos
Social Research Institute

Development Report:

2014 Outpatient Survey

A report prepared for the Bureau of Health Information
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1. INTRODUCTION

The NSW Patient Survey Program (the Survey Program) is a suite of surveys that collects information on the experiences of patients receiving care in public hospitals and other public healthcare facilities across New South Wales (NSW). The purpose of the Survey Program, which commenced in 2007, is to report on patients' experiences and perceptions of care in NSW public hospitals and public healthcare facilities so that:

- hospital performance is readily available to the general public; and
- health services and policy makers can identify strengths and opportunities for improvement, to assist them to provide safe, quality care.

The following principles underpin the Survey Program:

- participation is voluntary
- confidentiality of patients' personal information is assured
- questionnaires are informed by evidence
- information collected is reliable, comparable and relevant
- reporting methods are open and transparent
- information reported is impartial, easily understood and useful.

The Bureau of Health Information (BHI) currently manages the Survey Program on behalf of the Ministry of Health (MoH) and Local Health Districts (LHDs). BHI was established by the NSW Government to independently report on the performance of the public health system in NSW, including the healthcare experiences of patients. In 2012, Ipsos Social Research Institute (Ipsos SRI) was contracted by NSW Health to develop and administer a new suite of surveys for the Survey Program.

The redevelopment was designed to ensure that the content of the surveys and any new surveys are specifically tailored to the NSW healthcare environment (the surveys used from 2007-2011 were originally developed by NRC Picker for use in the United States). Where relevant, the surveys include a set of core, common questions. These core questions have been tested in the Adult Admitted Patient survey, the first of the suite to be developed, on behalf of the National Health Information Standards and Statistics Committee's Patient Experience Information Development Working Group (PEIDWG).

A program of research informed the development of the Outpatient Survey (OPS). The aims and objectives of the research were to ensure that the OPS adequately captures and provides feedback on the aspects of care that:

- are relevant to the current policy context
- are important to NSW patients

- will be useful to NSW health services and policy makers.

This report describes the research process undertaken to develop the OPS. The first chapters of this report summarise the information collated at each stage of the developmental process, resulting in a list of potential question areas. The final chapter documents how these potential question areas were prioritised and translated into the final survey.

The results of the survey will be fed back to the NSW Government and public healthcare facilities to inform service improvement, and released to the public.

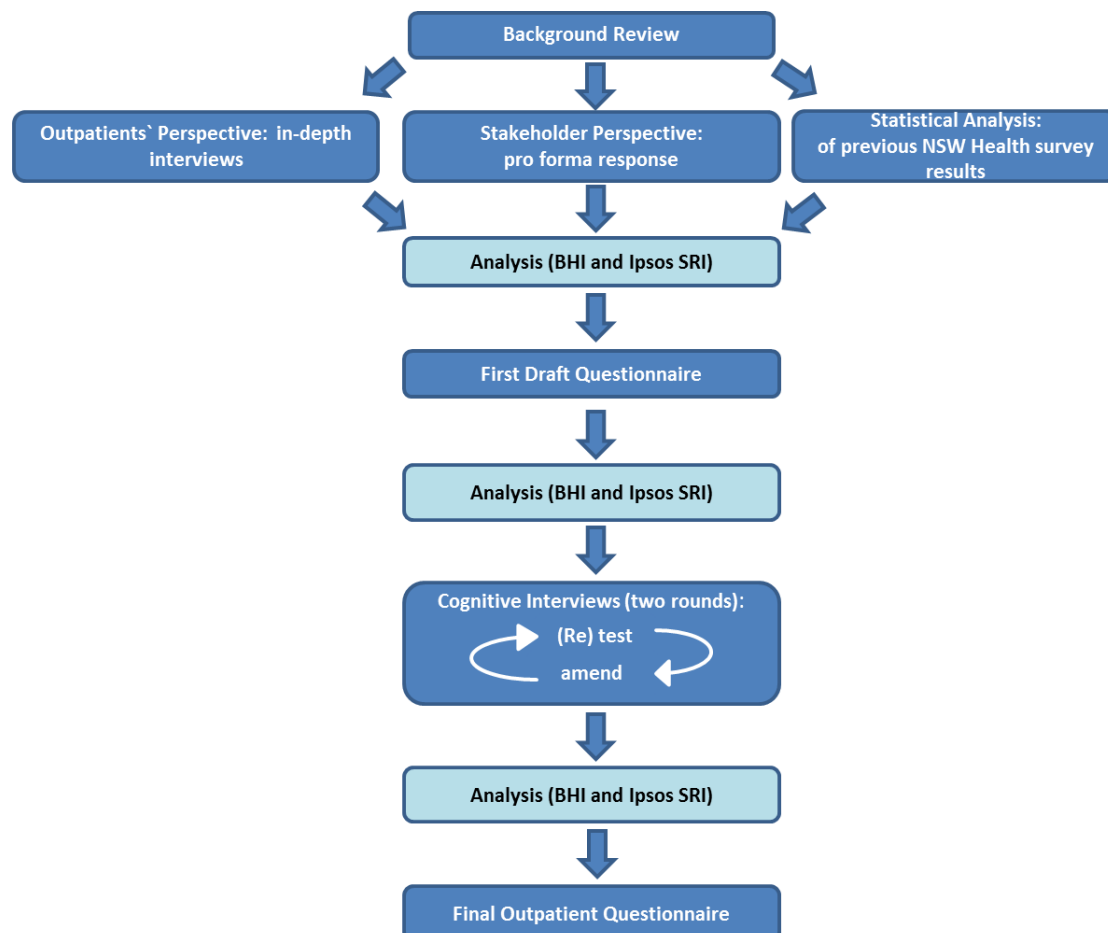
2. METHODOLOGY

The development process comprised:

- i. a rapid review of key literature (including policy documents and quality standards)
- ii. in-depth interviews with outpatients
- iii. stakeholder engagement
- iv. statistical analysis of the 2007-2011 NSW Outpatient Care Survey
- v. two rounds of cognitive testing
- vi. extensive discussion between the development teams at BHI and Ipsos Social Research Institute (Ipsos SRI).

The following diagram illustrates the questionnaire development process (Figure 1).

Figure 1: Questionnaire development process



Rapid literature review

The rapid literature review was performed to provide context and to broadly inform the content of the OPS. The aims of the review were as follows:

- 1) Identify and compare the core domains of treatment for outpatients and their care
- 2) Identify the most important current policies and quality standards relevant to the OPS (taking into account the suitability of the survey as a vehicle for assessment against these policies or standards)
- 3) Briefly describe and compare the format, content and questionnaire-related methodological issues associated with other jurisdictions' OPS instruments.

In performing this review, the following research questions were addressed:

- What do we know about the outpatient clinic patient experience that may be relevant to developing the OPS?
- What are the key drivers of outpatient experience identified within other jurisdictions' surveys?
- What are the most important current policies and quality standards relevant to the OPS?
- What are the core domains of care that are used in other jurisdictions' outpatient surveys?
- What are the key learnings from the literature/other jurisdictions' outpatient surveys in terms of the questionnaire design/format (for example, length or demographic questions included for standardisation purposes)?

In order to achieve the aims of the review and answer these research questions, a search of literature was completed by BHI in order to identify relevant research papers and grey literature. This search primarily involved both web and library-based searches using the following search terms: 'outpatient survey' 'ambulatory care survey' 'outpatient experience and satisfaction', 'outpatient questionnaire', 'health service questionnaire' 'hospital quality and safety' 'accreditation' 'patient experience domains' 'outpatient/patient survey sampling methods'

The search was restricted to original English-language papers, articles and reviews published since 1990.

These sources were synthesised to form the basis for the rapid literature review.

Patient in-depth interviews

Patient in-depth interviews were conducted in order to understand the range of experience of those attending outpatient clinics in NSW and, in particular, the aspects that were most important in creating a positive or negative clinic experience from the patient perspective. These topics were then collated with the findings from the other phases of the research before being reviewed by BHI and Ipsos SRI for potential inclusion in the survey.

Ten in-depth interviews were conducted with adults who had attended an outpatient clinic at a NSW public hospital within the previous 12 months, using a quota controlled sampling strategy to allow for a range of patients' views. The interviewee composition consisted of a mix of age groups, people from both metropolitan and non-metropolitan areas, and of outpatients across a range of clinic types. More information about the composition of those participating in the interviews is presented in Appendix A. The interviews were conducted between 9th and 19th December 2013.

A discussion guide was developed to ensure that key stages in the outpatient journey were discussed; from making an appointment, arrival at the clinic, through treatment and possible tests. The discussion guide used in the in-depth interviews is appended (Appendix B). Each interview was audio recorded in order to facilitate analysis and to provide verbatim comments.

An analysis session, involving all of the Ipsos SRI in-depth moderators, was conducted to establish common themes and points of difference between the ten interviews. This was followed by further analysis of moderator notes and recordings to provide a summary of the elements of the patient experience considered most important from the patient perspective.

Outpatient stakeholder engagement methodology

A range of key stakeholders were consulted on topics for inclusion in the OPS. The key stakeholder distribution list was compiled by BHI and included representatives from the following groups:

- Agency for Clinical Innovation (ACI)
- Cancer Institute NSW
- Central Coast LHD
- Clinical Excellence Commission (CEC)
- Far West LHD
- Health Education and Training Institute (HETI)
- Hunter New England LHD
- Illawarra Shoalhaven LHD
- Mid North Coast LHD
- Murrumbidgee LHD
- Nepean Blue Mountains LHD
- Northern NSW LHD
- Northern Sydney LHD
- NSW Ambulance
- NSW Kids & Families
- Port Macquarie Base Hospital
- South Eastern Sydney LHD
- South Western Sydney LHD

- Southern NSW LHD
- St Vincent's Health Network
- Sydney Children's Hospital Network
- Sydney LHD
- Western NSW LHD
- Western Sydney LHD.

These stakeholders were invited by BHI to suggest areas for inclusion in the OPS by submitting a pro forma response. The pro forma contained the following fields: aspect of care or question topic; reason for interest in this area; whether the question applied to a sub-set of patients; how the data would be used; and question phrasing (see Appendix C). The pro forma was distributed in December 2013 and was completed by 13 contributors. The contact email is appended (Appendix D).

Pro forma responses were then analysed and grouped by Ipsos SRI team members according to topic of suggestions. Relevance to patients and information on how the data would be used were both taken into account during the subsequent prioritisation process and questionnaire design.

The question areas indicated by the stakeholder consultation were collated with those identified from the other developmental phases of the research to create a comprehensive list of potential question areas for the OPS, which took into account the perspective of both patients and stakeholders.

References to stakeholders within this report refer to ideas and comments put forward by one or more of the consulted stakeholders, but are not necessarily the views of all, or a majority, of stakeholders.

Statistical analysis of previous surveys

Survey results from the 2007-2011 NSW Outpatient Care Survey were analysed using:

- 'Key drivers' analysis, to indicate which broad question areas were most closely related to overall satisfaction and should therefore be prioritised for inclusion in the survey.
- Factor and reliability analysis, to identify which factors accounted for much of the variance across the patient groups, again indicating that these areas should be prioritised for inclusion in the survey. The reliability analysis involved the identification of highly correlated questions, to indicate where two questions were likely to be measuring the same underlying issue and could therefore be combined or removed.
- Analysis of non-response and possible ceiling and floor effects, to suggest question areas that may be less useful for informing service improvement and/or where particularly

careful consideration should be given to questionnaire routing, question wording and response scales.

- Analysis of respondent comments relating to the survey itself, taken from the free-text survey question, to identify any issues that should be addressed in the new survey.

Further details are provided below and full technical details can be found in Appendix E.

Factor and reliability analysis

Filters were created for each patient group to ensure that each round of factor analysis only comprised a more homogenous group of patients who had filled out the same sections of the Outpatient Care Survey.

Consequently, the groups included in analysis comprised:

- 'general' patients (i.e. those who had not filled out the 'pain' or 'test' sections);
- 'pain' patients (i.e. those who had filled out the 'pain' section but not the 'test' section);
and
- 'test' patients (i.e. those who had filled out the 'test' section but not the 'pain' section).

Missing values were identified and populated for each of the patient groups using either modes (for scales with few response options) or means (for scales with more response options, or for scales where variance in responses was greater). Question scales were then standardised by allocating each response option a value between zero and 100 in equal increments, where zero represented the poorest level of performance and 100 represented the highest level of performance.

Principal Components Analyses were performed for each of the filtered participant groups using Varimax rotation to maximise the differences between factors. Questions that contributed to the variance of several factors were removed from the analyses to ensure meaningful factors. Factors were then analysed and named to represent the range of questions that they encompassed.

Following the identification of factors, the reliability and the pattern of inter-item association of their components were examined using Cronbach's alpha and correlation matrices.

Non-response analysis

The results from the 2007-2011 NSW Outpatient Care Survey were analysed to identify patterns of non-response in the data. These data were analysed using the filters for each question to identify the valid rates of non-response.

Ceiling and floor effects

The 2007-2011 NSW Outpatient Care Survey was also analysed to identify questions that exhibited possible ceiling or floor effects.

A ceiling effect is present for a measurement variable when the majority of scores are at or close to the highest possible score, indicating a loss of sensitivity in the upper register. Conversely, a floor effect is present when the majority of scores are at or close to the lowest possible score.

In order to determine the occurrence of true ceiling or floor effects, several criteria were used. These criteria comprised: a sufficiently small standard deviation (25 or less), a skewness statistic exceeding 1.5 or below -1.5, and a mean greater than 85 or less than 15. These criteria represent characteristics of a probability distribution that exhibits a ceiling or floor effect. The skewness statistic, in particular, has been demonstrated as a robust measure of test score ceiling and floor severity¹.

Dichotomous variables were excluded from the analysis because of the inherent response constraints of these questions.

Patient comment analysis

The NSW Outpatient Care Surveys included a final free-text question - "if you could change one thing about the hospital, what would it be?"

Comments made by survey respondents were entered into a data file and coded into themes. This analysis was used as an additional indicator of the aspects of the outpatient experience that were most important to patients. More importantly, all comments coded as 'other mentions' and/or containing the keyword 'survey' were manually reviewed for content relating to the conduct of the survey.

Cognitive interviews

Using all of the prior analysis, a new questionnaire was drafted. Two rounds of cognitive interviews were conducted with NSW outpatient clinic attendees in order to investigate how they interpreted and responded to the new questionnaire. This was performed to: ensure questionnaire validity (i.e. that questions were understood, consistently interpreted and measured what they were intended to measure); ensure that patients were able to follow the questionnaire routing instructions; ensure that they understood the cover letter; and as a final opportunity to confirm that individual questions were relevant to patients and that no crucial question areas were missing (from the patient perspective).

Questions identified as problematic in these interviews were redrafted and presented to patients in the subsequent round of the cognitive interviews, or removed altogether.

The interviews were conducted among a wide range of outpatients across the Sydney area. Quotas were set to ensure representation of a range of participants in terms of age, background (including culturally and linguistically diverse patients), household income and clinic type attended.

A total of 16 cognitive interviews were conducted between 14 April and 9 May 2014. The profile of participants in each round can be found in Appendix F.

Each interview was audio recorded and cover notes were prepared by Ipsos SRI consultants to facilitate analysis. The discussion guide used in the cognitive interviews can be found in Appendix G.

Analysis sessions involving Ipsos SRI and BHI

Throughout the development process, BHI and Ipsos SRI teams were in regular contact. This involved ad-hoc discussions, as well as a series of meetings held at the key stages of the development, including:

- following completion of the patient in-depth interviews and stakeholder feedback
- following each round of cognitive testing
- following each substantial redraft of the survey.

At each meeting, survey inclusions and exclusions were discussed, with decisions made in light of the results of the development components, BHI's expert knowledge of the NSW healthcare system, data analysis and reporting needs and Ipsos SRI's research expertise. Further, upon the drafting of the penultimate version of the survey, the survey was presented to the Survey Program's Strategic Advisory Committee for final review. Feedback from the committee was subsequently incorporated into the final version of the survey.

3. FINDINGS

3.1 Rapid review of key literature

Introduction

Outpatient services are commonly counted as non-admitted patient occasions of service and refer to individual and group sessions for services such as Allied health, Dental, Dialysis, Endoscopy and related procedures as well as medical/surgical/obstetric related.² Services can be provided before and after hospital admission or might not involve a hospital admission at all.

NSW Health conducted the Outpatient Care Survey from 2007-2011. BHI undertook a literature review in preparation of the planned 2014 OPS.

General aim and methods

This rapid literature review was performed to inform the content of an outpatient experience survey. The aim of the review was to determine the relevant policies and current best practice, internationally and nationally, in OPS development.

The process for this review incorporated the following:

- Identifying the relevant domains associated with patient experience and satisfaction with outpatient services
- Investigating local, national and international survey tools/initiatives
- Contributing to development of an appropriate survey tool for measuring outpatient experience in NSW.

The research approach primarily involved both web and library based searches utilising the common search terms for outpatient care.

Policy context

Service quality, and with that the emphasis on consumer centred care, is fundamental to a number of major policies that the NSW Ministry of Health (MoH) and Local Health Districts (LHDs) are committed to. Integral to this commitment is the need to measure patient experience and satisfaction to evaluate effectiveness and inform areas of need.

The National Safety and Quality Health Service (NSQHS) Framework³, endorsed by Health Ministers in 2010, specifies that quality care is consumer centred, driven by information, and

organised for safety. The Framework describes several aspects that underpin what consumer centred care means. These are as follows:

- Providing care that is easy for patients to get when they need
- Making sure that healthcare staff respect and respond to patient choices, needs and values; and
- Forming partnerships between patients, their family, carers and healthcare providers.

Also driving the imperative to measure patient experience is the need to report on National Healthcare Agreement indicators⁴ which Health Ministers are signatories to. As well, the Health Care Charter on Human Rights, which states that wherever and whenever care is provided it is to be of high quality and is safe⁵ is endorsed by Health Ministers and patient experience surveys can inform on the level of service compliance with this charter.

Domains of outpatient experience and satisfaction

A review of the literature revealed very little specific research into the domains of outpatient experience. Considerably more research has been undertaken to determine inpatient experience domains.^{6,7} However, the outpatient environment, and with it the experience for patients, can be quite different to the environment and experience for patients admitted into hospital. Only one paper completed in the last twenty years was identified in this literature review that specifically examined the key domains of experience for outpatients. This paper, prepared by Picker Institute Europe, reported the findings from a study that indicated a more diverse set of domains than those relevant to the experience of admitted patients.⁸

The study identified a number of domains on the basis of their prediction of patient satisfaction, their reliability, usefulness and correspondence with inpatient experience. These domains are as follows and are in descending order according to the strength of their effect on satisfaction. Picker proposed that the items in bold are the key domains for outpatients as they are among the strongest predictors of patient satisfaction; they are more reliable as they derive from a group of indicators (rather than a single question); they are more useful for quality improvement; and they correspond closely to the core domains of inpatient experience:

- Organisation of the outpatients department
- Respect and dignity
- **Dealing with the issue (for which patients presented themselves)**
- **Doctors**
- **Cleanliness**
- **Other professionals**
- **Information about discharge**
- **Information about treatment**
- Tests

- Medication
- Privacy.

The authors noted that the organisation of care and respect and dignity, while strongly predictive of outpatient satisfaction, are less useful for informing specific quality improvement actions as they are based on a single indicator (i.e. one question per each in the Picker survey) and are considered to be broader, overall ratings and thus less useful for informing specific quality improvement actions.

Additionally, analysis showed that information about discharge was much more predictive of outpatient satisfaction than it was for inpatient satisfaction, The authors hypothesise that this might be because assessment of inpatient experience “may be dominated by what happened during their stay in the hospital” while outpatients are responsible for managing their own care during the long periods they are away from medical staff. Therefore, securing information that helps them to manage better at home is more likely to be seen as an important outcome of their visit.

Approaches to OPS design and implementation

The literature search revealed that approaches to patient survey design and implementation within Australia are largely fragmented. A review of Australian patient surveys found that there are marked differences in methodologies, scope, rating scales, inclusion and exclusion criteria, sampling and reporting across public and private hospitals.⁹ Outpatient surveys, when they are conducted tended to be condition specific, such as cancer care¹⁰ , clinic specific¹¹ such as physical therapy, or hospital specific such as those administered by the Press Ganey commercial surveys used by a number of Australian private hospitals and hospitals in the United States as part of a broader quality improvement program.¹² The lack of a standardised approach to outpatient care survey development was also evident in other countries. A systematic review investigating outpatient surveys determined that it was not possible to conduct a meta-analysis of the material due to the large variation in methods.¹³ Interestingly, one conclusion drawn from this review was that although methods were not comparable, surveys conducted in hospital consistently yielded higher mean satisfaction ratings than surveys conducted later at home.

However, this current review revealed that there was one dominant patient care survey developer who provides an outpatient module. This provider was the Picker Institute who has developed and holds the intellectual property on a number of survey instruments conducted throughout countries in Europe, the UK and United States and also in NSW.

The Picker Institute surveys

The Picker Institute, founded in 1994, is an independent not-for-profit organisation that works in partnership with organisations in Europe and the US. The Institute sponsors awards, research and

education to promote patient-centered care as well as develop patient care survey tools. In 2001, the National Research Corporation acquired from Picker Institute Inc. the rights to use Picker surveys worldwide, excluding Europe, for the production, marketing and sale of survey-based satisfaction/performance measurement analysis and tracking services and products for the health care industry. NRC Picker and Picker Institute Inc. are not affiliated. Consequently, countries outside of Europe and the UK are only able to access Picker survey tools through the US based NRC Picker.

The 2007-2011 NSW Outpatient Care Surveys

The Outpatient Care Survey, administered by Ipsos on behalf of NSW Health was developed by NRC Picker. The survey had not been comprehensively validated as a complete instrument, nor was it clear how well it aligns with best-practice as defined in previous studies. An assessment of the NSW survey indicated that most of the domains were examined within the questionnaire but it was unclear how reliable these questions were in their current format.

The 2009 National Health Service Outpatient survey

Established in the UK in 2002, the National Health Service (NHS) Patient Survey Program was developed and pioneered by Picker Institute Europe, who coordinated the NHS programs on behalf of the Department of Health, then the Healthcare Commission and, most recently, for the Care Quality Commission. This literature review identified the NHS's questionnaire as the only comprehensive and widely distributed generic outpatient survey administered in English-speaking and European countries.

In 2009, Picker Institute Europe undertook a review of the NHS OPS for the purpose of establishing the most appropriate sampling frame and methodology and to identify issues most salient to patients.¹⁴ It also consulted on the scope of the survey in relation to national policies and tested the validity of the revised questionnaire in cognitive interviews.

The review determined, through focus group testing and stakeholder consultation, topic areas that were most important to consumers of outpatient services (see **Table 1**).

Table 1: Topic areas identified by the 2009 Picker Institute Europe review

Picker domain of outpatient experience	Topic area
Appointment and waiting	<ul style="list-style-type: none"> • Length of wait to receive appointment date • Choice of hospital • Flexibility of appointment date and time • Being told how long they would have to wait to be seen • Receiving an apology if the appointment was delayed • Appearance of the waiting room/area

	<ul style="list-style-type: none"> • Having a good range of entertainment facilities in case of delay
Facilities	<ul style="list-style-type: none"> • Spacious and cheerful looking waiting area • Good refreshment facilities nearby • Good entertainment facilities e.g. TV, books • Good parking facilities i.e. inexpensive, good availability, suitable payment method • Better signage around the hospital • Availability of hand wash gels
Staff and interpersonal relationships	<ul style="list-style-type: none"> • Having confidence and trust in the health professionals • Feeling reassured • Courteous reception staff • Being able to understand the explanations provided • Having the opportunity to ask questions • Awareness of medical condition • Seeing same professional on repeat visits • Feeling able to complain if necessary
Tests and treatment	<ul style="list-style-type: none"> • Information about where and when tests would take place • Being told how long to wait for test results • Test results being available when anticipated • Being able to ask questions about test results • Being fully informed about a treatment prior to it taking place
Information	<ul style="list-style-type: none"> • Receiving copies of letters sent between hospital and GP • Co-operation and coordination of care between hospital and GP • Being given important information in both verbal and written formats

Comparison between NSW Health and NHS Outpatient Survey instruments

In 2009, both the NHS and NSW OPS included questions from all the Picker domains of outpatient care, however, neither survey contained all topic areas identified in the 2009 review. With regards to the NSW OPS (2007-11), this questionnaire did not cover seven of these topics, specifically:

- choice of hospital
- facilities in relation to spaciousness, availability of refreshments
- signage
- seeing the same health professional
- being able to complain
- being able to ask questions about tests; and,
- receiving copies of letters sent to doctors.

The NSW OPS (2007-11) contained 79 questions. The 2009 NHS survey had 58 mandated questions with an additional 82 extra questions that could be added by hospital Trusts. Other major differences between the two questionnaires are as follows:

- Question wording and response options can be quite different when comparing questions examining the same topic. For example, in relation to waiting time between making the appointment and attendance, the NSW survey asks "When was the appointment made for this visit?" with response categories ranging from "Less than 24 hrs before visit" to "More than 4 weeks before visit". The NHS asks, "From the time you were first told you needed an appointment to the time you went to the Outpatients Department, how long did you wait for an appointment?", with response categories ranging from "Up to one month" to "More than 18 months".
- Questions in the NHS survey appear to be more comprehensive than the NSW OPS. For example, questions relating to before the appointment in the NHS ask about what knowledge the patient had about the visit; were they given information about their condition: the reasons for their appointment; any changes to their appointment; whether given a choice of hospital; and whether they knew who to contact about their symptoms if they got worse. These aspects were not examined in the NSW survey.
- The NHS survey asks specifically 'did the patient see a doctor?' and then asks questions specific to the interaction, such as confidence and trust and whether the doctor had enough information about the patient's history. It then asks similar questions about other health professionals. The NSW survey does not distinguish between doctor and health professionals.
- The NSW survey asks about patients' psychological state at time of appointment but the NHS does not.
- The NSW survey asks about pain management and hygiene practices of staff whereas the NHS survey does not.
- The NHS survey asks questions about information provided to patients at discharge, such as: whether they received copies of letters sent between hospital and doctors; were they given printed or written information about their condition or treatment; information on what the next steps were for the patient. The NSW survey does not examine this aspect of care other than asking whether the patient knew what danger signs to look out for; and explanations about the medication.
- Both surveys include the same question examining the patient's overall impression of the visit. Both surveys also include a question on whether they would recommend the service to others. It should be noted that some research indicates that the reliability of a recommendation question is inconclusive as evidence suggests that patients do not always understand the question properly, interpreting it instead to ask whether they would recommend their problem being attended to.¹⁵

- In the final comments section of the surveys the NSW survey asks the patient to nominate one thing about the service they would change. The NHS asks the patient not only about possible changes but also about what was particularly good about the visit.

Issues concerning sampling strategy

There are important considerations in relation to identifying the most appropriate sampling strategy for an outpatient survey. This mainly concerns the determination of the population group to be surveyed. Firstly, consideration must be given to who the broad overarching group will include. For example, does the group include only those people who attended an outpatient clinic, or those people who were referred to an outpatient service, irrespective of whether they attended? Selection of the latter group would enable the survey to examine more comprehensively, issues around access, treatment compliance and attitudes to outpatient care. Although it is important to know what the outpatient experience is, perhaps it is better to also know the perspective of those who needed outpatient services, but did not access them. However, the major difficulty with this population group is in identifying a robust data source from which to obtain this sample.

A further consideration regarding patient population group is the inclusion and exclusion criteria within this group. Consideration needs to be given to: determining age-groups (i.e. children or just adults); whether the survey will be administered to people who cannot read and write in English; or to people with low literacy levels. Consideration also needs to be given to the sensitivity of an outpatient clinic group e.g. sexual health; alcohol and drug; mental health; and level of acuity of the patient group, for instance, oncology and radiation. All these factors need to be considered in the development of a sampling strategy. It is important to balance the need for information against the potential distress or disruption to a patient.¹⁶

Discussion

While both the NSW and the NHS OPSs contain questions on most of the domains identified as important in the literature, the absence of 'information at discharge' in the 2007-11 NSW OPSs represents the absence of a critical area. This domain is an important part of the transition and continuity of care regarding outpatients and therefore, inclusion of questions that measure this is important for properly assessing performance in this area.

Another area for consideration is the inability in the NSW survey to discriminate between a doctor and other health professionals. Having this distinction in the questionnaire might allow for greater attribution of results, allowing targeted improvement of clinic performance. However, this must be considered in context of the proportion of patients who see health professionals other than doctors.

A final inclusion that would benefit the NSW survey is a second freetext question in the final section asking respondent to describe something that was particularly good about the service. This

would provide valuable information over and above understanding only what was wrong with the service.

It is important to note that the NHS survey instrument has undergone extensive testing for internal and external validity and reliability, both in terms of the questions themselves and the instrument as a whole. The literature review also revealed that the NHS core domains have been tested for their strength of association with outpatient experiences of care. There are advantages to the survey program in using these existing domains or reviewing them for use in NSW.

The length of the questionnaire should be kept to around 12 pages in length as supported by a Picker Institute Europe analysis.¹⁷ At this length, there should be minimal effect on decreasing response rate and this research also notes that the quality of the data is not compromised by questionnaire lengths of up to 12, or even 16, pages.

Finally, consideration should be given to identifying the population groups to be surveyed, for example whether children, mental health and drug, alcohol and sexual health services are included. This would need to be determined through analysis of administrative and past survey data, as well as consultation with key stakeholders.

3.2 Outpatient in-depth interviews

Findings

This section summarises the aspects of the outpatient clinic experience that were most important to those who took part in the in-depth interviews. Generally, people were positive about their outpatient experience. The key themes, both positive and negative, that were identified about outpatient experiences are described below. More detail about this process can be found in Appendices A and B.

Arranging appointments

Patients were generally referred to an outpatient clinic by their GP (for less severe conditions) or a specialist (for more severe conditions). In the majority of cases, the clinic was based at patients' local hospital. While patients were generally not offered a choice of hospitals, it was not an area of complaint.

Most patients indicated that they were not given much information about what to expect from their outpatient treatment. This was generally not a point of contention as most patients were not sufficiently worried about the type of treatment they were to undergo, as to feel the need for such information. They did not expect to be given information on their prognosis and the likely trajectory of their outpatient treatment. Those with more serious conditions, who tended to be more concerned about their treatment – such as oncology patients – were more likely to have been provided with information from the referrer about what to expect from their treatment at outpatient facilities.

The length of time between referral and the first appointment was among the most common complaints. Several patients were required to wait for months for their first appointment. For many, waiting time expectations were low, however others were upset by the delay.

"Like all [outpatient] appointments, you get an appointment in two months. I did get an appointment at the end of January, but I got a call saying that they would have to defer this...and it's now mid or late February."

"The booking process is just a mess. Three months to see the doctor is just crazy! The reason that we go and get ourselves treated is so that we don't have to wait and prolong the problem."

Time spent waiting for follow-up appointments was also a prominent issue for some patients.

"The receptionist said 'He'll only get the chance to see you in another three months'. I go 'what?! The doctor just told me he'd see me within a month!' They told me they can't see me until next year."

In most cases, it was patients rather than referrers who scheduled the appointments. While no negative feedback was received specifically in relation to this process, some patients indicated that organising the appointments themselves entailed unnecessary hassle which could otherwise have been avoided. Patients mentioned having to make appointments in person, rather than over the phone, and not being able to call to arrange an appointment until after a certain date as their clinic's books had been 'closed off'.

"I wasn't able to book an appointment over the phone. This meant I had to go to the clinic physically just to make an appointment."

"I had to make an appointment for neurosurgery but couldn't because they had closed their books. They wouldn't take any more bookings for a certain period. I had to call them again in a few months when their bookings reopened. I've found that with a couple of them."

There was also dissatisfaction among some patients in terms of when their appointments were scheduled. These patients felt that they were not provided with a date and time that fitted into their schedule. This tended to occur mainly because the clinics they were referred to only operated on specific days and times.

Getting to the clinic

Convenience of travel to the clinic differed between patients. For many, their clinic was located at their local hospital, which meant that, for them, transport was not an issue. These patients indicated that they could walk or catch a bus to the hospital, often with a total travel time of half an hour or less.

Those who lived further from their clinic found access far more problematic. Such patients often indicated that the process of travelling to, and parking near, their clinic set a negative tone for the remainder of their experience. In the case of one patient with a spinal problem, finding a parking spot was so difficult that they could no longer travel to appointments on their own: this patient indicated that they had to be driven to the hospital by their partner and dropped off in a convenient location.

"Parking spots are a nightmare. Sometimes you waste time driving around and what not. Now I tend to take someone with me so that they can drop me at the door. I've done it on my own and it gets too much."

Other patients indicated that while they were generally able to find a parking place, it was often extremely expensive given the length of time that they could spend at outpatient appointments.

"You can find parking but it's very expensive – it cost me \$25 on Tuesday."

"You're waiting 2 hours and they're charging 8 bucks an hour. It's not the patient's fault."

Once patients arrived at the hospital, getting to the clinic was generally considered easy. For the most part, clinics were relatively well sign-posted and some patients had even been given directions prior to their appointment by their referrer or the clinic's reception staff. One patient also mentioned that within the hospital itself there were information points with staff members who could provide them with directions to the clinic.

On the other hand, some patients found navigation more difficult. In one case, the hospital a patient was attending was undergoing renovations and lacked clear directions to the outpatient clinic. This patient noted that their outpatient facility was frequently attended by elderly patients most of whom they thought would find it extremely difficult to navigate through the hospital during these renovations.

Waiting

Length of time spent waiting at the clinic was one of the most defining parts of the outpatient journey. Most patients were given a specific time for their appointment at the clinic. Where this was not the case, patients were simply told to arrive early to avoid a long wait.

In general, upon presentation at the clinic, patients were told by the reception staff to take a seat and wait for the health professional to be ready. At this point, there was a divergence in the experiences of the patients: some only had to wait for five to ten minutes, while others had to wait for as long as five hours until the doctor was ready to see them.

"I thought it was going to be a five hour wait, but it was actually a five minute wait – they got to me straight away."

"It's never ever on time. I never go in [to see the doctor] straight away. The wait is anywhere between one to five hours."

"You might have an appointment at 2:30. You don't see anyone 'til 4:30...you know, these guys should be paying me."

For patients who only had to wait for a short period of time to see the health professional, the time spent in reception was not recognised as a prominent part of their patient experience. These patients were generally complimentary about the process and the waiting room facilities. Conversely, patients who had to wait for a long period of time tended to be more critical of the process, the reception staff and the waiting room facilities.

The manner and conduct of reception staff tends to impact patients' overall experiences at the outpatient clinic. Some patients indicated that a positive experience, where reception staff were friendly and helpful, tended to fill them with confidence, assuring them that they were being well looked after.

"They were lovely and smiling. This made me feel as though they are genuinely interested in taking care of you."

"The reception staff were very good humoured and polite. There was no problem there."

"I came straight from work so I didn't have my Medicare card...so they said 'ok sure we'll run you through the system and have a look.'"

On the other hand, some mentioned a negative experience led to them questioning the quality of care that they were to receive in the outpatient clinic.

"Having reception staff who don't want to deal with you makes you feel uneasy. The affect is huge. You're thinking, what else will they do if they don't care about their job?"

Most of the patients who had to wait for extended periods indicated that they would have been less upset if they had been notified about the wait – or even an indication of the length of wait – by reception staff upon presentation or prior to their appointment. While some of these patients noted that reception staff provided them with information on the length of wait when they requested it, they thought that it would have been better practice to inform them spontaneously. Some also complained about the professionalism of the staff in answering their queries about the time that they had to wait.

"I came in to the clinic, the nurse told me to take a seat, then 2 hours later she told me 'you're not on the books'. It hadn't been registered that I was there. The doctor had gone home"

*"They're just so relaxed ... it's like they don't give a ****. You're standing at the table, and she's going over there, then she goes to chat to her friend, and then she comes back. You're staring at her, and she's said 'one minute sir.' She finally gets to you, when she gets to you."*

Some of those who had to wait for long periods of time had spoken to others in the waiting room and found out that they were given the same appointment time as several other patients. These patients were highly critical of this method of taking appointments and questioned why the clinic would operate in this fashion. Some were also of the opinion that too many appointments were being made for the same day.

"It's just stupid how they have all the consultations lumped together. Like you'll be sitting in the waiting room and sometimes you talk to the person next to you and everyone's got the same appointment [time]. Maybe five or six people at 9 o'clock, five or six people at 10 o'clock."

*"The amount of people at the clinic out the ***** door ... it's a shock to see that many people ... crammed in like sardines. Are we gonna be processed like a production line? 'G'day, how you goin', see ya later'"*

The same patients tended to complain about the facilities within the waiting room itself. Primary grievances of these patients included there not being enough to occupy them in the reception area whilst waiting – for example a lack of magazines or television – as well as uncomfortable seating arrangements, and a lack of chairs in the waiting room. The latter complaint was particularly prevalent among older and less able patients.

"Maybe more comfortable chairs [would improve waiting]; sometimes there aren't enough chairs so people have to wait outside."

"There were not enough chairs as the line went through the door, meaning we were standing for 50 minutes. For someone who's not feeling particularly well, who's drugged up, this is a difficult situation."

Interaction with medical staff and treatment

Patients were almost unanimous in their praise for the medical professionals they were treated by at their clinics. Characteristics commonly attributed to the range of health professionals included friendliness, respectfulness and clarity of communication. Most patients indicated that once they were in the treatment room they were: taken through the details of their treatment, including the likely course of treatment; notified about the types of tests that they would undergo; and notified about the details of the medications being prescribed to them. Patients often noted that the health professionals took their time and that they never felt rushed or that the health professional was trying to hurry them up, which helped to instil them with a sense of confidence and trust in the doctor.

"If the doctor was working on a tight schedule and I'm sure she is, there was no evidence of it. There was no rushing me in, no hurrying me out or getting rid of me. She was very good. I had a feeling when she was with me that she was focused totally on my matters."

"Attention to you, not one eye out the door."

"Good to have someone who is enthusiastic... they were great because they genuinely seemed interested in their jobs. They cared."

"They were engaged, upbeat and happy."

Further, while the patients observed that the health professionals possessed knowledge of their medical history and expertise on the conditions that they were suffering from, they communicated clearly and without jargon. This was particularly important for younger patients and those who were nervous about their condition or upcoming treatment; the health professionals' kind disposition and the clarity of their communication helped to alleviate stress and to put them at ease.

"They take the time to explain what they're doing and if there are any problems, they'll take the time to explain it to you and listen to you."

"He was very friendly with his answers as well. It wasn't all serious and professional – he was speaking to me at a level which I'd understand."

Empathy was not only demonstrated in communication with the health professionals, it was also evident in the treatment they provided. Patients with sensitive issues such as sexual disorders noted the tact that health professionals used when discussing symptoms and the method of treatment. Some of these patients also observed that the health professionals genuinely cared about resolving the problem without relying on the use of medication as a crux in treatment.

"[The health professional] went through the whole process for me of getting an answer for me without using medication."

"The big thing is empathy."

There were, however, some exceptions. In one case, clinic staff did not explain the course of treatment nor the potential number of appointments to a patient. Another patient was originally informed that their operation would be carried out by an experienced surgeon with whom they had an established relationship. Instead, most of the treatment was performed by a registrar. In another instance, a patient was taken into a private room for a doctor's diagnosis, only to be told that someone else needed the room and that they be evaluated elsewhere. Each of the above patients saw this as a violation of trust.

"You don't want to feel cheated. You're under anaesthetic, so there's a trust issue there. What they say is going to happen is what needs to happen."

"You don't feel like a valued person. You feel like just a number."

Another facet of health professionals' care that was praised by patients was their hygiene practices. Almost all of the patients interviewed indicated that the health professionals washed their hands or put on a clean pair of surgical gloves before examining them. Patients generally indicated that hygiene was not one of their primary concerns in their treatment as an outpatient.

However, some expressed a very high level of concern regarding hygiene, and noted that they had been quite observant of hygiene practices throughout their treatment.

Where there were concerns about hygiene levels, they were generally very minor. Some related their concerns regarding hygiene practices to the feeling that their quality of care was lacking and was slightly less than they would have received as a private patient.

"I didn't actually see him clean his hands after using the stethoscope"

"You never see them use the foam things ... cross infection is potentially massive"

A common complaint from patients was a lack of staff continuity over time. This was a particularly prevalent concern among those who received treatment over months or years. Such patients were often seen by different health professionals for each separate appointment. While they were not concerned with the level of care provided by each health professional, they typically mentioned feeling that receiving care and treatment from a single individual would have been preferable for two reasons: firstly, because that health professional would possess knowledge of the patient's background that went beyond their hospital record; and secondly, because they had already established a trusting relationship with the previous health professional. However, these patients noted that they did not expect this sort of continuity of care in the public health system, acknowledging the low levels of staffing in outpatient facilities state-wide.

Tests

Some of the patients with more serious health conditions required blood and/or bone density tests as part of their appointments at the outpatient clinics. These tests were generally carried out by health professionals at other clinics within the same hospital, either directly after the initial appointment with the health professional at the outpatient clinic or at a subsequent time. The outpatient clinic's health professional invariably arranged (at least) the first appointment on behalf of these patients, an approach which was greatly appreciated.

"Overall, I was very happy and relaxed with [the referral]. The service, the recognition of who I was, the matching up of the records ... I thought it was all very efficient."

Patients often indicated that they had to wait after presenting at the pathology or x-ray clinic. Time spent waiting at these locations tended to range between half an hour to two hours, and was often in waiting rooms that were either consistently over-crowded or lacked proper seats for the waiting patients.

Results of these tests were delivered back to the patient by their outpatient health professional, often at their next appointment. One patient mentioned that if the results of the blood test were other than what was expected, they were contacted directly by their health professional.

Explanations of the results of the tests provided to the patients were consistently thorough and devoid of medical terminology.

Leaving the clinic and follow-up

Following appointments, patients were told by the health professional when they should next present for treatment or a check-up. After their first appointment, the health professional would generally accompany the patient to the reception desk to schedule this follow-up. Subsequently, patients themselves would book these appointments at reception.

Generally speaking, patients were not overly concerned with the process following their appointments. In most cases, patients felt aware of danger symptoms to look out for when they went home. These patients were mainly notified who they could contact if they were worried about their condition and what to look out for.

In some cases, there were exceptions. For example, some were not explicitly informed of how medications work or side effects to be aware of. Others were not explicitly offered the opportunity to return to the clinic in the case of further issues.

"I didn't ask [about the side effects of the medication] and he didn't tell, not in that bad sort of way. I just didn't ask and he didn't think he needed to elaborate I'm guessing ... I'd expect them to say something now that I'm thinking back on it."

List of potential question areas from patient in-depth interviews

Based on the findings outlined above, the following areas were identified for potential inclusion in the OPS, alongside those indicated from the other stages of the development process.

Arranging appointments

- Mode of making the appointment
- Ease of making the appointment, if it was made themselves
- Suitability of appointment date and time for their schedule
- Waiting time between making an appointment and the appointment taking place

Getting to the clinic

- Mode of arrival
- Ease of parking and finding the clinic
- Cost of parking

Waiting

- Attitude of reception staff – politeness, empathy, a friendly greeting
- Professionalism of reception staff
- Waiting time

- Information on outpatient process and approximate waiting time from reception staff
- Comfort of the waiting room
- Facilities available in the waiting area

Interaction with medical staff and treatment

- Confidence in the ability of doctors/nurses
- Attitude of doctors/nurses – friendliness, respectfulness, trust and reassurance
- Communication of doctors/nurses
- Hygiene of staff
- Cleanliness of treatment areas
- Privacy considerations

Tests

- Explanation of need for tests
- If tests undertaken, were results received by patient or GP

Leaving the clinic and follow-up

- Provision of information on how to take care of themselves when they went home, including medication and possible side effects
- Whether patients felt they received the treatment/outcome they required
- Opportunities for follow-up treatment if necessary

3.3 Stakeholder engagement

This section summarises the aspects of the outpatient experience that were most important to stakeholders.

Referral to the outpatient clinic

Stakeholders were interested in the inclusion of questions relating to the patients' knowledge about the process of their referral to the outpatient clinic. In particular, stakeholders were interested in whether patients were cognisant of the reasons for their referral, and indeed, if they were aware that a referral had been made.

This topic was deemed important for inclusion by stakeholders because patient consent is required for outpatient referral; hence, patients need to be fully informed about the process, including the reasons that they were referred and how treatment in the outpatient service could benefit them. Stakeholders indicated that the inclusion of these question areas in the survey could help provide feedback to services and subsequently help improve clinics' performance in this aspect of care.

Getting to the clinic

Several stakeholders mentioned the need for survey questions relating to patients' transit to the clinic. These stakeholders were particularly interested in whether it was easy for patients to find a parking spot when arriving at the clinic. Furthermore, once a spot was found, stakeholders were curious about the ease with which patients could walk to the clinic and whether they felt the entrance to the hospital was clearly sign-posted.

Stakeholders also suggested that questions relating to the availability of other forms of transport should be included in the survey. Specific question areas of interest to stakeholders included whether alternative forms of transport to the clinic were available to patients, and if so, whether these forms of transport were financially affordable.

The rationale for including these question areas was that anecdotally outpatients often cancel their clinical appointments due to transport difficulties getting to the clinic. Inclusion of such questions in the survey would yield data which could be fed back to outpatient clinics to illustrate their general level of accessibility. Such information could then be provided to patients in order to forewarn them of any accessibility issues so that the on-time running of appointments could be maintained by clinics.

Waiting

Waiting time was of high priority for stakeholders. Stakeholders were interested in patients' experiences of waiting at all stages of outpatient care, including: any difficulties that patients had in getting an appointment; length of time that patients had to wait to secure an appointment; and time spent waiting for the health professional at the clinic. They also noted that it would be useful to incorporate other questions relating to patients' waiting experiences into the survey, including: the perceived suitability of the waiting room environment for specific patient groups (paediatric outpatients, for instance); and whether it was necessary for patients to escalate their concerns about their wait times (by means such as contacting their general practitioner to expedite the process).

These question areas were of interest because stakeholders felt that waiting for prolonged periods can cause patients undue levels of stress. Further, information generated by the inclusion of such questions could be used to help develop more accurate appointment time slots which would help facilitate outpatients' treatment pathways and minimise the stress associated with waiting.

Interaction with health professionals and treatment

Another of the most prominent question area for stakeholders was patient interaction with health professionals. Stakeholders were interested in questions that encompassed different forms of communication between patients and health professionals, as well as patients' overall perception of the treatment they received at the clinic.

Specific question areas relating to patients' communication with health professionals included: whether health professionals introduced themselves to patients; whether patients felt that the health professionals spent enough time with them; the usefulness and comprehensibility of information provided by the health professionals; whether patients had the opportunity to ask the health professionals questions; and whether they understood the answers. Stakeholders indicated that they thought these question areas are important inclusions because they observed that patients tend to receive a lot of information (both from health professionals and in written form) throughout their treatment at outpatient clinics. In order for patients to properly self-manage their care, they need to properly understand what is being communicated to them. Inclusion of questions relating to these matters in the survey would generate evidence that could be fed back to facilities to help improve their provision of information and enable patient-centred care.

Stakeholders were also interested in the inclusion of questions relating to patients' perceptions of the adequacy of their treatment at outpatient clinics. Suggested question areas included: whether patients felt suitably involved in decisions made about their care (particularly those relating to end of life discussions); whether patients felt health professionals treated them with respect and dignity; whether patients felt staff respected their privacy and confidentiality; patients' perception of what is being done well at their outpatient clinic; patients' perceptions about what could be

done better at their outpatient clinic; and whether they were satisfied with the care provided by the health professionals. Stakeholders envisaged that the inclusion of these questions in the survey would yield data that could be used in system improvement at clinics. Further, they felt that results that indicated exemplary performance could be fed back to clinics to recognise those who excelled in the care of patients.

One stakeholder was also interested in patients' perceptions of the appropriateness of the attire of health professionals working in the clinic. This stakeholder felt that the results from this question could be used to improve patients' perception of staff by improving the suitability of their attire.

Physical environment of the clinic

One stakeholder suggested the inclusion of questions relating to the physical environment of the outpatient clinic. This stakeholder indicated that they felt that questions relating to whether patients felt the clinics were safe and comfortable and whether patients felt that the clinics were clean and tidy should be incorporated in the survey. According to this stakeholder, such questions would help to clarify the performance of clinics with regard to these drivers of patients' satisfaction.

Leaving the clinic

The final question area suggested for inclusion by stakeholders related to the discharge of patients following their appointment. Specifically, stakeholders were interested in the provision of information to patients as they were leaving the clinic, including questions such as: whether patients were provided with care plans following their appointments; and whether patients were made aware of what they should do if their condition changed. These topics were considered necessary inclusions in the survey as adequate care in these areas helps to facilitate patients' self-management away from the clinic. It was thought that the feedback of survey results to clinics could help enhance clinical performance at discharge.

List of potential question areas from stakeholder engagement

Based on the findings outlined above, the following areas were identified for potential inclusion in the OPS, alongside those indicated from the other stages of the development process.

Referral to the outpatient clinic

- Whether patients were aware of the reasons for their referral
- Whether patients were aware that a referral had been made.

Getting to the clinic

- Whether patients found a parking spot at the clinic
- Whether patients were able to walk to the clinic from their parking spot

- Whether alternative forms of transport to the clinic were available
- Whether these alternative forms of transport were affordable.

Waiting

- Whether patients had difficulties making an appointment
- Length of time that patients had to wait to secure an appointment
- Length of time spent waiting for a health professional at the clinic
- Perceived suitability of the waiting area (particularly for specific patient groups, including paediatric outpatients)
- Whether it was necessary for patients to escalate their concerns about the waiting time.

Interaction with health professionals and treatment

- Whether the health professional introduced themselves to patients
- Whether patients felt the health professional spent enough time with them
- The usefulness of information provided by the health professional
- The comprehensibility of information provided by the health professional
- Whether patients had the opportunity to ask the health professionals questions
- Whether patients understood the answers to their questions
- Whether patients felt involved in decisions made about their care
- Whether patients felt that health professionals treated them with dignity and respect
- Whether patients felt staff respected their privacy and confidentiality
- Patients' perceptions on what is being done well at the clinic
- Patients' perceptions on what could be done better at the clinic
- Whether patients were satisfied with the care provided for them at the outpatient clinic
- Perceived appropriateness of health professionals' attire.

Physical environment of the clinic

- Whether patients felt that the clinic was safe and comfortable
- Whether patients felt that the clinic was neat and tidy.

Leaving the clinic

- Whether patients were provided with care plans following their appointment
- Whether patients were told what they should do if their condition changed.

3.4 Statistical analyses of previous surveys

Results from the 2007-2011 NSW Outpatient Care Survey were analysed using factor and reliability analysis, analysis of non-response and possible ceiling and floor effects, and analysis of respondent comments relating to the survey itself. This analysis informed the development of the new OPS by providing additional indication of question areas likely to be most important, question areas where particularly careful consideration should be given to the wording/response scales, and question areas that could potentially be removed. The results of these analyses are as follows. For further technical details, please see Appendix E.

Factor analysis

The factor analysis generally provided consistent results across the range of outpatients: general outpatients (those who did not experience pain or undergo tests), outpatients who experienced pain (who did not undergo tests) and outpatients who underwent tests (who were not in pain). For all three of these groups, the factor that accounted for the highest amount of the variance was the *Health Care Professionals* factor (from 14-22% of the variance), indicating that outpatients' experience of Health Care Professionals is the facet of care that best helps to discriminate between experiences. This factor comprised questions pertaining to Health Care Professional competency, communication skills and their general demeanour; adequacy of explanations regarding treatment; patients' level of involvement in their care; and perceived adequacy of pain management (for outpatients who experienced pain). The reliability for this factor was consistently very good to excellent (Cronbach's alpha 0.87-0.92), suggesting that these questions were measuring the same latent construct. Further, for all patient groups, the factor that accounted for the second highest amount of variance was the *Overall treatment* factor (10-16% of the variance), which encompassed questions relating to patients' overall experiences in the outpatient clinic. This factor largely comprised the same questions for all of the patient groups and demonstrated similarly robust levels of reliability for each group (their alpha values were all higher than 0.9).

Despite the general consistency between the results for the various patient groups, there were also some differences observed. For outpatients who experienced pain and outpatients who underwent tests, factor analysis yielded a *Facilities* factor, which comprised questions relating to noise levels in and cleanliness of the clinic, as well as availability of parking. While this factor did not account for a great deal of variance (around 4%), its presence suggests that such characteristics of outpatient clinics help to distinguish the experiences of outpatients who experienced pain and outpatients who underwent tests.

Unsurprisingly, for patients who underwent tests, the analysis yielded a *Tests* factor. This factor comprised questions relating to the scheduling of tests and the explanation of the test results. While the factor only accounted for 5% of the total variance, its presence differentiated the experience of outpatients who had tests from the two aforementioned patient groups.

High correlations between variables

As part of the reliability analysis, inter-item correlation matrices were produced for each factor. These matrices were examined to identify redundant questions within factors. Follow-up Pearson correlations were conducted to check the correlation across patient groups.

It is important to note that high correlations between variables can be an artefact of participants' response patterns. Therefore, the questions mentioned below are questions that possess strong correlations^I with each other as well as similarity in question wording or topic.

In the 2007-2011 Outpatient Care Survey, two pairs of questions fulfilled the aforementioned criteria:

- Q56. How would you rate the explanation of what was done to you? & Q55. How would you rate the completeness of care that you received for your problem?
- Q60. Overall, how would you rate the care you received in the Outpatient Clinic? & Q55. How would you rate the completeness of care that you received for your problem?

The analysis suggests that these pairs of questions could potentially be redeveloped as a single question without reducing insight into outpatients' experience.

Other questions with slightly lower correlations^{II} included:

- Q15. Did someone tell you when you would find out the results of your tests? & Q14. Did someone tell you how you would find out the results of your tests?
- Q57. How would you rate how well the Health Care Professionals worked together? & Q55. How would you rate the completeness of care that you received for your problem?
- Q61. Using any number from 0 to 10, where 0 is the worst Outpatient Clinic possible and 10 is the best Outpatient Clinic possible, what number would you use to rate this Outpatient Clinic at your visit? & Q60. Overall, how would you rate the care you received in the Outpatient Clinic?

The above questions' position in the survey should be considered. While they may not necessarily be measuring the same construct, they appear to be measuring similar constructs (for example, when a patient would find out the results of their test and how a patient would find out the results of their test). If additional brevity is needed, these questions could possibly be redeveloped or combined.

Missing response analysis

A missing response analysis was performed on the data from the 2007-2011 Outpatient Care Survey to determine whether particular questions in the survey were prone to non-response.

^I Pearson correlations of more than 0.8

^{II} Pearson correlations of more than 0.7

The experiential questions in the 2007-2011 surveys that exhibited the highest rates of non-response were Q67. What areas of the Outpatient Clinic were not clean? with 78.5% non-response and Q22. If you and a Health Care Professional didn't talk about your questions, was it because...? with 23.7% non-response. It appears likely that these questions had such high levels of non-response due to their format: both had a list of response options with a 'mark all that apply' instruction, and neither had a preceding routing/filter question. While Q22 did have an option for patients who did not have any questions, there was no such 'opt out' response option for Q67.

Questions within the 'Your tests' section of the questionnaire also exhibited elevated rates of non-response, ranging from 5.6-6.5%. Possible explanations for this result include:

- Outpatients that require tests may regularly attend the outpatient clinic for these procedures. As a result, they may have found it difficult to answer questions relating to a discrete visit to the Outpatient clinic or even remember the specific visit to the clinic that they were being asked to recall.
- Outpatients may not have regarded tests as a salient part of their outpatient experience.

Ceiling and floor effects

The questions with more than two response options from the 2007-2011 Outpatient Care Survey with a ceiling effect (i.e. indicating that the majority of patients gave a positive rating), according to specified criteria were as follows:

- Q19. Did you have trouble talking with the Health Care Professional because of a language problem?
- Q24. Did the Health Care Professional treat you with respect and dignity?
- Q44. If you needed another visit with this Health Care Professional, did the staff do everything they could to make the necessary arrangements?
- Q41. Did your healthcare providers/staff wash or clean their hands before providing care for you?
- Q18. Did the Health Care Professional listen to what you had to say?
- Q42. Did your healthcare providers/staff wash or clean their hands after providing care for you?
- Q17. When you saw the Health Care Professional, did he or she give you a chance to explain the reasons for your visit?
- Q58. Sometimes, one Health Care Professional will say one thing and another will say something quite different. Did this happen to you in the Outpatient Clinic?
- Q20. When you asked questions, did you get answers you could understand?
- Q9. Did you have to wait too long in the examining testing area?
- Q23. Did you have confidence and trust in the Health Care Professional treating you?

One question exhibited a floor effect (i.e. indicating that the majority of patients gave a negative response). This was:

- Q43. Did you remind or prompt staff about hand washing before they provided care for you at any time during this visit?

The identification of ceiling/floor effects for these questions indicates that they might be less useful in terms of informing service improvement, which is one consideration when prioritising potential question areas for inclusion in the outpatient questionnaire. However, they should not be automatically excluded from the questionnaire because: while that aspect of care may appear to be functioning well at an overall level, there may be problems with some of these aspects of care at the individual hospital or LHD level; patients should feel the survey covers areas of importance to them; positive feedback from the results of the survey is likely to be important for staff morale; and the survey is one avenue for facilities to provide evidence of compliance with standards and for accreditation.

Patient comment analysis

The OPS included an open question, which asked 'If you could change one thing about the service or clinic, what would it be?' Comments made by survey respondents in 2011 were coded into categories. All comments coded as 'other mentions' and/or containing the keyword 'survey' were manually reviewed for content relating to the actual conduct of the survey. Examples of these comments can be found in Appendix E.

Recommendations based on the analysis include:

- Consideration should be given to the date at which the survey is sent out to patients (as some patients mentioned that sending out the survey closer to their visit would improve their responses to some questions).
- The sample frame should be examined to ensure that the survey is only sent to outpatients with clinical experiences relevant to the content of the questionnaire (as some respondents mentioned that the survey content was not applicable to their outpatient experiences).
- The survey should include a question that establishes if it was completed by the patient or someone else.
- The information accompanying the survey should clearly explain which specific visit to the clinic the patient should be basing their survey responses on (as some respondents' comments indicated that their responses were based on their experiences in a different visit to the one that they were sampled for).
- Consideration should be given to the formatting of the questionnaire to ensure that it is easy for older patients to understand and complete.

Implications of this analysis on the design of the OPS 2014

- Key domains in the survey should include: Interactions with health care professionals, overall ratings of care, tests, medication, waiting in the clinic, hygiene, facilities, follow up appointments and waiting for an appointment.
- Pairs of highly correlated questions should be combined to ensure that redundancy of questions in the new survey is minimised. Specifically:
 - Q56. How would you rate the explanation of what was done to you? & Q55. How would you rate the completeness of care that you received for your problem?
 - Q60. Overall, how would you rate the care you received in the Outpatient Clinic? & Q55. How would you rate the completeness of care that you received for your problem?
 - Q15. Did someone tell you when you would find out the results of your tests? & Q14. Did someone tell you how you would find out the results of your tests?
 - Q57. How would you rate how well the Health Care Professionals worked together? & Q55. How would you rate the completeness of care that you received for your problem?
 - Q61. Using any number from 0 to 10, where 0 is the worst Outpatient Clinic possible and 10 is the best Outpatient Clinic possible, what number would you use to rate this Outpatient Clinic at your visit? & Q60. Overall, how would you rate the care you received in the Outpatient Clinic?
- Questions with a list of response options and a 'mark all that apply' instruction should be avoided as they lead to high levels of non-response. Further, wherever possible, routing questions should be used for the same reason.
- The presence of ceiling and floor effects should be taken into consideration when prioritising question areas for the survey.
- Consideration should be given to the date at which the survey is sent out to patients, with a preference for closer proximity to the date of discharge.
- The sample frame should be examined to ensure that the survey is sent to patients with experiences relevant to the content of the outpatient questionnaire.
- The information/cover letter accompanying the survey should clearly explain which specific visit to the outpatient clinic the patient should be basing their survey responses on.
- The survey should include a question that establishes if it was completed by the patient or by their parent or guardian.
- Consideration should be given to the formatting of the questionnaire to ensure that it is easy for older patients to understand and complete.

4. QUESTIONNAIRE DEVELOPMENT

This section summarises how the various stages of the development process were brought together - the rapid literature review, the statistical analyses, the stakeholder consultation and patient in-depth interviews.

This process involved:

- Applying parameters/rules to guide the questionnaire development
- Creating a list of potential question areas for inclusion in the survey instrument
- Consideration of other implications arising from each stage of the development
- Extensive consultation between BHI and Ipsos
- Multiple rounds of cognitive testing.

Potential question areas

The potential question areas indicated by each stage of the development process were brought together to create a comprehensive list of possible topics. This included a range of issues relating to:

- experience of making an appointment
- waiting time prior to appointment date
- mode of transport to the outpatient clinic
- availability and cost of parking
- waiting time at appointment
- comfort of the waiting area
- attitude of staff
- organisation and communication between staff
- information provision and communication with patients
- privacy
- complaints
- cleanliness and hygiene
- competency of staff and quality of treatment
- provision of care plans
- provision of new medication
- overall ratings of care
- patient suggestions for improvements
- demographics and health status information (including questions required for standardisation purposes)
- data linkage permission.

The full list of potential question areas can be found in Appendix H.

This comprehensive list, drawn from all developmental stages, was used as the basis of the initial questionnaire design, and then refined through consultation and testing.

Development of rules/design parameters for the questionnaire design

The design of the OPS built on the rules and design parameters established in the development of the Adult Admitted Patient survey (AAPS). The same planned approach – of consultation with patients and stakeholders, and review of ‘best practice’ patient surveys – was adopted. Questions that had been developed and tested in other surveys were used where appropriate. Similarly, the design was an iterative process between BHI and Ipsos, finalised during cognitive testing.

These common rules and design parameters included: that the primary focus should be the patients’ experience of care and factual rather than judgemental assessment; inclusion of an overall rating question; use of balanced rating scales; avoidance of double-barrelled questions (wherever possible); avoidance of leading or biased question wording; using a limited suite of question formats and response options for ease of completion; using plain English throughout; and providing ‘don’t know’ and ‘not applicable’ options only where essential.

BHI has prioritised the inclusion of the National Core Common Questions, as determined by PEIDWG, where possible in the questionnaires. This means another consideration is that these questions should only receive minimal adjustment when converting their use to other survey tools.

Cognitive testing

An essential part of the development process was the undertaking of cognitive testing to ensure the validity of the questionnaire. As with AAPS, the aim of this was to ensure that participants were able to understand and answer the survey questions and that they were consistently interpreted in the way intended. This stage of development was particularly valuable given the large variety in outpatient experiences and pathways that it highlighted.

The cognitive interviews were conducted in two rounds. The first round provided an opportunity to assess whether the instrument successfully captured the full range of outpatient experiences. This was an iterative process with the findings from the first round informing the subsequent draft, and being tested in the second round until a final draft was achieved. This was then graphically designed to ensure that the layout of the questionnaire encouraged participation and supported successful completion of the survey.

A summary of the edits made as a result of the cognitive testing phase and subsequent discussion between BHI and Ipsos SRI, follows below:

- An opening question was added to determine which type of clinic the patient attended (as some attend more than one at a specified hospital) and due to privacy concerns, the clinic name was not specified on the questionnaire cover letter.

- Access to clinics, both in terms of navigation and mobility, emerged as concerns for patients and questions were introduced to address these points.
- Questions were added to establish how well clinics attended to paediatric patients, in terms of facilities in the waiting area, and the way in which staff interacted with young patients.
- Questions were introduced to address the issue of different members of medical staff attending to patients at each appointment.
- Patients were not always familiar with the idea of a 'care plan', and whether or not this had been provided during their clinic appointment. Questions were introduced to assess this point, and the wording was revised for better comprehension.
- Access questions were also introduced to establish whether patients had to pay out-of-pocket expenses, and whether this had an impact on follow-up medication, tests or treatment.

Appendix I details the development process for every individual question in the final survey, including the primary reason for inclusion, the source question (where applicable) and changes made to the question during the development process (as a result of cognitive testing and discussion between BHI and Ipsos SRI).

Appendix J outlines which questions in the final survey are relevant to the National Safety and Quality Service Standards and the Australian Charter of Healthcare Rights.

The final questionnaire is included in Appendix K.

Development of the questionnaire for use in the NHS Outpatient Department Survey 2009

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