



Ipsos
Social Research Institute

Development Report:

2015 Small and Rural Hospitals Survey

A report prepared for the Bureau of Health Information
August 2016

Contact details

BUREAU OF HEALTH INFORMATION

Level 11, Sage Building

67 Albert Avenue

Chatswood NSW 2067

Australia

Telephone: +61 2 9464 4444

bhi.nsw.gov.au

IPSOS SOCIAL RESEARCH INSTITUTE

Level 13, 168 Walker St

North Sydney NSW 2060

Australia

Telephone: +61 2 9900 5100

<http://ipsos.com.au/>

Ipsos SRI project reference: 11-043092

Ipsos SRI project contacts: Andy Cubie, Jessica Elgood and Robert McPhedran

This work is copyright. It may be reproduced in whole or in part for study or training purposes subject to the inclusion of an acknowledgement of the source. It may not be reproduced for commercial usage or sale. Reproduction for purposes other than those indicated above requires written permission from the **Bureau of Health Information, Level 11, Sage Building, Chatswood, NSW 2067**. Copyright Bureau of Health Information 2016.

Suggested citation:

Ipsos Social Research Institute. Development Report: Small and Rural Hospitals Survey. Sydney (NSW); 2016.

Please note that there is the potential for minor revisions of data in this report. Please check the online version at bhi.nsw.gov.au for any amendments.

TABLE OF CONTENTS

1. Introduction	1
2. Methodology	3
3. Findings	7
3.1 Evidence check	7
3.2 Small and rural hospital patient focus groups	11
3.3 Stakeholder engagement	17
4. Questionnaire development	19

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. 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 questionnaires 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).

During the period the Survey Program was managed by the NSW Government, the surveys were sent to patients from all health facilities across NSW. However, the results for some facilities were never reported, due to the small number of respondents. When the program was redeveloped, BHI and the Strategic Advisory Committee for the Survey Program agreed to boost sample numbers where possible. They also decided to exclude smaller hospitals from the main surveys including the Adult Admitted Patient Survey, the Emergency Department Survey, the Admitted Children and Young Patient Survey and the Outpatient Survey.

A program of research informed the most appropriate way to develop the Small and Rural Hospitals Survey (SRHS). The aims and objectives of the research were to ensure that the SRHS 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 SRHS. 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 questionnaire.

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.

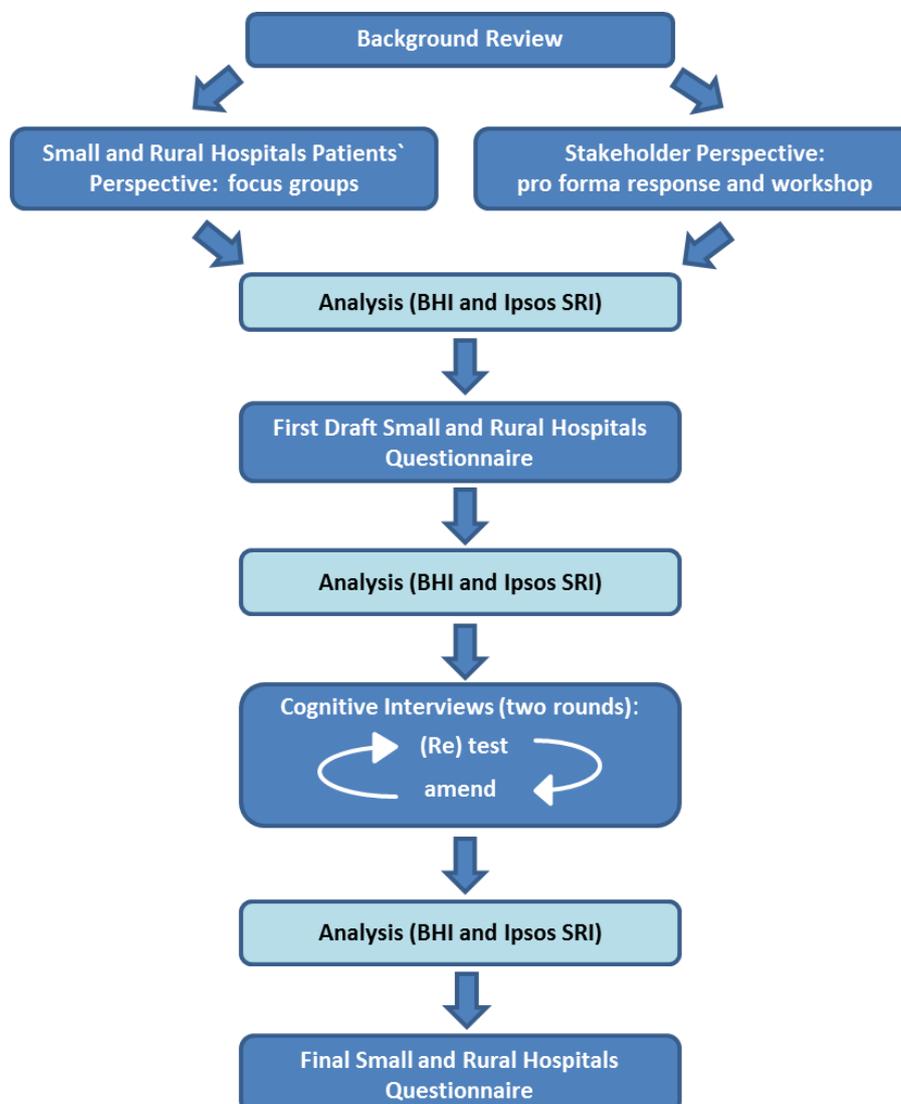
2. METHODOLOGY

The development process comprised:

1. An evidence check to identify appropriate methods for collecting patient experience information in smaller facilities
2. Focus groups with small and rural hospital patients
3. Stakeholder engagement
4. Two rounds of cognitive testing
5. 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



Evidence check

In 2014, BHI commissioned an evidence check to identify appropriate methods for collecting patient experience information in smaller hospitals. The evidence check was conducted at the beginning of the survey development process to inform the scope, questionnaire design and sampling strategies to be used. More detail on the evidence check and the key findings are presented later in this document.

Patient focus groups

Patient focus groups were conducted in order to understand the range of experience of patients attending small and rural hospitals in NSW and, in particular, the aspects that were most important in creating a positive or negative hospital 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 questionnaire.

Four focus group discussions were conducted with adults who had been admitted to small and rural hospitals (peer groups F3, D1a and D1b) within the previous 12 months (36 participants in total), using a quota controlled sampling strategy to allow for a range of patients' views to be accounted for. The design matrix is appended (Appendix A). The focus groups were conducted between the 8th-9th October 2014.

The four specific locations were selected because of their varying size, and distance from larger health facilities. Their populations varied between 1,100 and 6,000.

Two focus groups were conducted with patients aged 17-45 years and two with patients aged 45 or more years. Two patients who had delivered a baby within the last year were recruited for each of the younger groups so that the discussion could also cover experience of maternity facilities in these areas.

A discussion guide was developed to ensure that key stages in the patient journey were discussed; from accessing primary care, arrival at the emergency department or referral, treatment, possible transfer to a larger facility, through to discharge. Prompting was used only if key issues were not spontaneously raised. The discussion guide used in the focus groups is appended (Appendix B). Each group was audio recorded in order to facilitate analysis and to provide verbatim comments.

An analysis session was conducted to establish common themes and points of difference between the four groups. This was followed by further analysis of moderator notes to provide a summary of the elements of the patient experience considered most important from the patient perspective.

Stakeholder engagement

In September 2014, 51 stakeholders were sent a pro forma inviting them to submit the content they thought was suitable for inclusion in the questionnaire (see Appendix C). The stakeholder list was compiled by BHI and is included in Appendix C.

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 suggested question phrasing. The contact email was sent by BHI and is appended (Appendix D). The pro forma was out in the field for a total of three weeks (a reminder was sent out to all those on the stakeholder list who hadn't replied halfway through the consultation period). It was completed by 11 contributors, including representatives from:

- Agency for Clinical Innovation (ACI)
- Far West LHD
- Hunter New England LHD
- Northern NSW LHD
- Southern NSW LHD
- Western NSW LHD
- NSW Kids and Families
- NSW Ministry of Health

This exercise was followed up in November 2014 with a workshop in which the project Advisory Committee - including representatives from Murrumbidgee LHD, Western NSW LHD, Rural Health Executive Network, HETI, ACI and the Ministry of Health - were invited to further refine the content for the questionnaire along with BHI and Ipsos SRI. BHI analysed the pro forma responses and feedback from the workshop. 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 and workshop were eventually collated with those identified from the other developmental phases of the research to create a comprehensive list of potential question areas for the SRHS, which took into account the perspective of patients, parents/carers of patients and other stakeholders.

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

Cognitive interviews

Two rounds of cognitive interviews were conducted with NSW patients who had attended small or rural hospitals and/or their parents/carers in order to investigate how they interpreted and responded to the first draft of the 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 respondents 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 respondents and that no crucial question areas were missing (from the respondent's 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 second round of cognitive interviews was conducted to test refinements to the questionnaire, along with the layout of the printed questionnaire and the other materials to be sent with the survey (i.e. accompanying letter and language information sheet).

The interviews were conducted among a wide range of patients from rural and regional areas. Quotas were set to ensure representation of a range of participants in terms of age and whether they had an emergency or a planned admission.

A total of 12 cognitive interviews were conducted between the 9th-24th February 2015. The profile of participants in each round can be found in Appendix E. Each interview was audio recorded and cover notes prepared by Ipsos SRI consultants to facilitate analysis. The discussion guides used in the cognitive interviews can be found in Appendix F.

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 after:

- Completion of the patient focus groups and stakeholder consultation
- Each round of cognitive testing
- Each substantial redraft of the questionnaire.

At each meeting, questionnaire 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, the questionnaire was presented to BHI's Strategic Advisory Committee (SAC) for final review. Feedback from the SAC was subsequently incorporated into the final version of the questionnaire.

3. FINDINGS

3.1 Evidence check

In 2014, BHI commissioned an evidence check to identify appropriate methods for collecting patient experience information in smaller hospitals¹. The questions specified for the review were:

1. What survey methods are currently used to assess patient experience in small health facilities?
2. How are survey methods most effectively used for assessing patient experience in small health facilities settings?
3. Which other measurement methods are currently used in assessing patient experience in small health facilities settings?
4. What are the domains of patient experience that have been measured in small health facilities settings?

Summary of Australian approaches to measuring patient experience in small facilities

Very little information was available from Australian organisations, including state and territory health departments, towards the questions of the current evidence check. The main approach to measuring patient experience in small facilities mentioned by individuals or found in relevant reports/websites was to survey all patients within a facility (i.e. census) rather than selecting a sample. Also note that at the time of the review, the Victorian Health Department was considering the use of hand held survey devices in small facilities to enhance participation and also to supplement the Victorian Healthcare Experience Survey (VHES) approach to ensure that these facilities are obtaining feedback on their performance.

The approach used by the Northern Territory is also worth noting, which is to undertake face to face interviews rather than a mail survey. While this is primarily aimed at obtaining patient experience information from people whose first language may not be English, and obtaining patient experience in a more culturally appropriate way, it also assists in obtaining higher response rates.

¹ Mazevska D, Pearse J. Surveying patient experiences at smaller facilities: an Evidence Check rapid review brokered by the Sax Institute (www.saxinstitute.org.au) for the Bureau of Health Information, 2014.

Summary of international approaches to measuring patient experience in small facilities

A review of websites and contacts with key international organisations with a role in patient experience identified three key strategies for achieving minimum numbers of completed patient experience surveys for statistical robustness:

1. Use of a census rather than sampling
2. Techniques to boost response rates, such as publicising the survey to patients and staff, making the survey available in multiple languages (or offering an interpreter service), and strategies to reach those that are difficult to reach (e.g. day and evening calls for people who may work shifts).

Results from scholarly literature

No articles specifically relating to the research questions were found during the review. The articles with a specific focus on patient experience and facility size investigated the relationship between these two factors rather than commenting on any methodological issues regarding obtaining patient experience information from patients attending smaller facilities.

Overall, the literature in this area seems to focus on differences in patients' perceived quality of care (as measured through patient experience surveys) based on two factors: the characteristics of the hospitals and the characteristics of the patients treated. Apart from size, other characteristics of hospitals studied were location (rural versus metropolitan/ urban) and teaching status. In terms of patient characteristics, age, education level and health status were studied.

Summary of findings

This evidence check began with four questions. These questions and a summary of the findings are outlined below.

The first question was "*How are survey methods currently used to assess patient experience in small health facilities?*"

The closest related information drawn from the evidence check is that most of the international systems and some of the jurisdictional-based approaches in Australia use a census approach to sampling for facilities where the sample size for a period is not expected to be sufficiently large enough to draw statistically viable results.

Also, studies analysing patient experience data from general practice and/or individual physicians identify three strategies for reducing the sample size needed to get reliable estimates for comparison between practices/ physicians:

1. Ensuring the reliability of individual questions. Questions which are not reliable need to be responded to by a larger number of people for statistical viability
2. Using composite measures to increase the reliability of some measures
3. Pooling data over a longer period of time. (This was mentioned in relation to data from sub-populations where responses are too low for reporting in each round, but could also be used for whole facilities and/ or for specific questions where responses are not sufficiently large for reliable comparisons.)

The second question was *"How are survey methods most effectively used for assessing patient experience in small health facilities settings?"*

No articles were found that answered this question specifically in relation to small facilities. Generally, literature on the superiority of one administration mode over another is mixed, potentially reflecting differences over time. While the literature has consistently shown mixed methods of survey administration to yield the greatest response rates, responses using different approaches are potentially biased and would require adjustment of results to make them comparable across modes. However, deriving factors for such an adjustment is a resource intensive undertaking.

Other methods that may assist in increasing response rates specifically for patient experience surveys are: making the surveys available in multiple languages and/ or providing access to an interpreter service for completion of the survey, making contact with patients about the survey prior to their discharge from hospital (including ensuring that their correct contact information is on the database), and publicising the survey to both patients and staff. Some of the strategies for increasing response rates to questionnaires generally (i.e. not specifically patient experience questionnaires) are pre-notification, follow up contact, shorter questionnaires and providing a second copy of the questionnaire at follow up.

The third question was *"Which other measurement methods are currently used in assessing patient experience in small health facilities settings?"*

There was no specific literature found on other measurement methods for assessing patient experience specifically in small health facilities. However, there is a body of literature on a range of other available approaches for eliciting patient experience information which may be relevant to small facilities.

The final question was *"What are the domains of patient experience that have been measured in small health facilities settings?"*

None of the patient experience tools/systems used by the major health systems around the world or Australia mentioned measuring a different set of domains of patient experience for patients

seen in smaller facilities. Where patient experience surveys are standardised across a state/territory or a country, the same survey applies to all facilities within scope, and no restrictions to scope on the basis of size were mentioned.

Overall, the information gleaned from the literature for the evidence check was limited. However, it provided some suggestions on strategies to increase the sample size and improve response rates of survey based approaches for eliciting information from patients about their experience with hospitals. These are:

- Use of census rather than sampling
- Strategies to improve response rates, namely:
 - Making surveys available in multiple languages (although it is noted BHI already offers an interpreter service to assist patients who may have difficulties in responding to the survey in English)
 - Informing patients about the survey prior to their leaving hospital
 - Publicising the survey amongst patients and staff.

3.2 Small and rural hospital patient focus groups

General perceptions of healthcare in rural areas

Patients understood that by living in regional and rural areas, the positive lifestyle aspects of such localities also brought with them certain drawbacks in terms of access to services, such as health care. Overall, they were broadly positive about the healthcare they received and were particularly positive about the healthcare professionals they interacted with. Given the smaller nature of these communities, the health professionals generally lived within the community they served, were often referred to on a first name basis, and were well known to the patients. Patients' concerns mostly focused around issues related to access to care, and were generally seen as a counter-balance to the many other benefits of living in these communities – namely, the sense of belonging to a strong community, where individuals knew and 'looked out' for one another, a more relaxed pace of life and proximity to the bush. While patients were broadly positive about living in these locations, and the quality of public services, the topic that stood out for criticism was the lack of provision of public transport, which impacted on access to healthcare.

Some patients made use of the local pharmacists as a preliminary line of care, rather than going directly to the GP – others did not. Those that did not consult the pharmacist tended to see them as a provider of medicine, not of health advice or care.

Access to healthcare

In three of the four locations, access to primary care was straight forward and easy. In marked contrast to the other locations, access to a GP was a major concern in one location. It was perceived that there were limited appointments available for pre-booking, and patients felt that older people with on-going medical conditions were booking these in advance, making it difficult for others to see a GP when needed. They were left with the option of making an 'on the day' appointment, which meant a call to the GP surgery at the beginning of the day, in the hope of getting one of these limited appointments, or the prospect of turning up at the surgery and potentially waiting for hours to be seen. Neither of these routes was seen as acceptable to patients, who were busy either with caring responsibilities or work. Some were aware of an app that would tell them when a GP may have a free appointment within their area but this could still mean up to an hours' drive to get to a surgery in a nearby town.

In these locations, there was generally little choice of GP to attend, and while patients were very positive about the care received from these health professionals, they were critical of not being able to access healthcare with bulk billing. Younger patients were particularly concerned about this, and as a consequence, patients reported presenting to the ED rather than the GP, to save money.

The pathway of care experienced by patients trying to access these smaller hospitals was frequently less predictable, and less 'traditional' than that observed in more metro areas. Broadly, patients would either present at the ED, or be sent by their GP, but the smaller size of the local communities meant that patients frequently knew medical staff very well, leading to more informal routes to care. While many would present in the same way as those accessing larger hospitals, given the close nature of relationships with health professionals, some would either phone the ED or GP directly to discuss what they should do. This may be to establish their treatment needs, but was also just as likely to be a means of working out where the doctors were most readily available or which doctor was on a shift at that time. For example, in one location patients would ring to find out whether the doctor was currently doing ward rounds at the hospital, was at the health centre or in the ED, so that they presented themselves in the location where they would be seen the quickest. In one of the group locations, patients mentioned that there was only one doctor and two nurses at the hospital, so they would frequently call to talk through the best course of action, rather than presenting themselves at the hospital. This doctor was very flexible, volunteering to make home visits, and also making himself available around the clock. One patient gave the example that they knew the doctor was attending a local social event, so they rang him on his mobile, rather than going to the hospital.

"If he doesn't think someone's fair dinkum, then he won't treat them. Some swear by him, some swear at him."

As a consequence of these informal routes into healthcare, there was very little discussion around waiting times when accessing the ED or hospital. Having established whether or not staff were busy, patients would either choose not to address their health issue, delay presentation, or drive to a different hospital.

Given the greater distances that patients lived from the hospitals, it was not generally seen as worthwhile calling an ambulance as they could drive or be driven to hospital before the ambulance could reach them. Only in circumstances where there was no-one capable of driving was an ambulance called.

Several of the smaller hospitals did not have reception staff. This meant that it was generally the nursing staff who met patients on arrival.

Care and treatment

Patients were overwhelmingly positive about the care received from health professionals, and, broadly speaking, the smaller the community, the closer and more positive the relationships and higher the rating of the care received. Patients tended to be marginally more complimentary of nursing care than of the doctors, with patients appreciating the time and personal attention they received from the nurses. They believed this was a key benefit of being treated in a smaller

hospital – that they knew the doctors and nurses taking care of them, that the ratio of staff to patients was better, and that the nurses were less rushed.

They reported positive experiences of staying overnight in the small hospitals, finding the nurses friendly, helpful and responsive when they needed their attention. In contrast, patients described overnight stays in larger hospitals as crowded, and reported often having to wait a long time for a nurse to help them. (It's worth noting that it is likely that they are admitted for more minor issues at their local facilities than at larger hospitals, and as a consequence, are likely to be less uncomfortable, less worried and potentially in less pain).

Opinion of the treatment received was more mixed. While all patients were quick to say that the health professionals did an excellent job with the facilities they had available, there were numerous examples of patients presenting at the hospital and the health professionals not having the knowledge or equipment to diagnose or treat them. This was noticeably different from previous discussion groups with patients in metro areas.

Some of the hospitals were described as dilapidated and antiquated and the facilities were perceived as having declined over the last 10-20 years. One patient gave the anecdote that his broken ribs went unidentified by the doctor using an older x-ray machine in one location, but were immediately diagnosed when x-rayed in the large regional hospital. Another patient gave an example of a snake bite that went undiagnosed by all three doctors at the small hospital, and they were only able to identify the problem by phoning health professionals elsewhere. However, there was a broad acceptance that these limitations were acknowledged by both health professionals and patients – it was not realistic to expect state-of-the-art expertise in small hospitals – and they worked within these limitations.

"You know, they're not doing brain surgery with chop sticks and a butter knife!"

In all four groups there was frustration that while each small hospital had an x-ray machine available, the radiographer was only available one day per week meaning that the machine lay idle, and they either had to wait to be scanned, or travel to a facility elsewhere.

Concerns about privacy or pain management were not raised in any of the four groups.

Maternity

There was some variation in the provision of maternity care. Those in one location were required to attend both ante- and post-natal appointments in a large regional hospital; those in a second location said they received shared care, between their GP and the local hospital. Some patients had received care from a regional community midwife, but were conscious that she had a huge geographical area to cover and that this service was under-resourced.

Those being cared for at one of the larger small hospitals were able to give birth there, but while they could receive a spinal block in the case of an emergency caesarean, they were not able to receive an epidural for pain management during labour. Some mothers chose not to give birth at this hospital, and preferred to drive 50km to a slightly larger hospital in a nearby town where the facilities were considered cleaner, better resourced and with more services.

"There's a few who give birth in the Wombat Hotel, because they didn't make it all the way to (medium-sized regional town)!"

One patient narrated her experience of miscarrying at the small hospital. As she was not in labour, it was not considered necessary to transfer her to the large regional hospital, however she felt that the doctors at the small hospital did not know how to treat her, and nor did they plan the follow-up care that she felt was necessary.

Specialist care

There was criticism about the referral process to specialists; namely the time and cost involved. Some patients gave examples of where the GP did not have up to date, or accurate, information on which specialists to refer to – meaning that time and money was wasted attending appointments with a specialist who was not in fact able to help them or their child. There was concern that travelling to Dubbo, Wagga or Sydney for a referral was not convenient, and that the reimbursement for the expense of staying overnight was insufficient. The costs of visiting a specialist were sometimes seen as so prohibitively high that patients would delay until the problem became urgent, and then they would present as an emergency. Others reported lengthy delays in getting to see specific specialists – for example, a nine week delay to see a gerontologist and an 11 month delay to see an orthopaedic surgeon. Patients also reported frustration that having received an appointment – for example, for knee surgery – these appointments could be repeatedly cancelled by the specialist or the hospital.

Those who had an ongoing condition (or a family member with one), were particularly frustrated at the endless cycle of referral they were required to go through to access the specialist. While knowing that they would need to see the specialist again in, say, 10 months, they could only do so by being re-referred by their GP and incurring additional expense. This cycle was seen as pointless, adding cost and benefitting no-one, and there was irritation that they could not simply book a follow-up appointment directly with the specialist.

Transfer

The process of transfer to a different hospital was not perceived as a problem. Patients either chose to drive themselves, be driven by a family member or friend, or were taken by ambulance. There was acceptance that an ambulance may take longer given the large distances needed to reach their rural homes, so patients frequently preferred to use their own car so as to get to the larger hospital quicker.

Concerns around transfer of care to a larger hospital focused on the experience at the larger regional hospitals. Experience varied depending on which regional hospital the patient visited. While some were broadly positive, others felt that the larger regional hospital was chronically understaffed, with excessive waiting times and very crowded waiting areas. All four groups preferred to be treated in their local hospitals, if at all possible. While the health professionals were recognised as having greater expertise and access to more modern technology, patients dreaded going there, and would consider strategies to avoid doing so because of the wait times and conditions. For example, they would drive themselves to a nearby medium-sized hospital to avoid being transferred to the large regional hospital.

Patients in three of the four groups were critical that the health professionals at larger regional hospitals were new migrants, trained overseas, whom they found difficult to understand. They described the staff in racially insensitive terms, and some perceived these health professionals as operating to lower standards of care that they believed were acceptable overseas.

"They're all Indian staff and they don't speak English"

There was also criticism that when transferred to larger hospitals they might be treated by student doctors who were not sufficiently experienced, nor supervised. Several patients cited examples where the student doctors had made it clear they did not know what to do, and understandably patients lacked confidence and trust in their care.

"The student doctor said 'What are we going to do – this is in the too hard basket'"

Discharge

The discharge process was straightforward, and raised few concerns for patients. Those in the smallest hospitals liked the fact that they were generally unrushed, whereas patients in the larger of the small hospitals were more likely to feel that they were being discharged when they might have benefitted from a longer stay in hospital.

The main issue raised by patients was that they may have no way of getting home from hospital after discharge. If they have been transferred to a large regional hospital by ambulance, there is no public transport to get home, meaning that they were reliant on friends and family being willing, and available, to pick them up. This was especially a concern for those patients who lived alone.

There was also some criticism that the local pharmacy may not have the medicine prescribed by the GP or hospital staff and as a consequence they might have to delay the start of their treatment while the medicine was sourced, or brought in from a large regional town. There was also some concern that the pharmacy may not be open at the weekend, again meaning possible delay in starting medication.

Summary – Implications for the design of the SRHS

Based on the findings outlined above, the following areas were identified for potential inclusion in the questionnaire.

Access to healthcare

- Whether an emergency arrival or a referral
- Waiting time for referral
- If an emergency arrival, whether sought telephone advice before attending hospital

Care and treatment

- Attitude of health professionals – politeness, empathy, concern, ability to communicate effectively
- Confidence in the ability of health professionals
- Accuracy of diagnosis
- Whether hospital had the equipment necessary to treat patient

Specialist care

- Waiting time to see a specialist
- Whether referred to an appropriate specialist
- Cost of specialist care

Transfer

- Method of transfer – car or ambulance
- Whether patient's injury/condition was dealt with or whether they were transferred or referred to a different facility to conclude their treatment

Discharge

- Whether patient felt ready to be discharged
- Whether transport home was a problem
- Whether able to get medication promptly from pharmacy, or delayed

3.3 Stakeholder engagement

Fifty-one stakeholders were invited to submit content they wanted to see included in the questionnaire. Sixteen stakeholders participated, submitting 52 additional topics or questions for inclusion. In addition, a workshop was held in which the project Advisory Committee further refined the topics. Five clear themes emerged from this exercise.

Emergency department presentations

Stakeholders and workshop attendees are interested in including questions that are specifically related to presentations at emergency departments and the reasons why patients make the decision to present to or leave the emergency department:

- Reasons for attending the emergency department
 - Do patients present to the emergency department because they are unable to access primary care or community care services?
- Reasons for leaving the emergency department without treatment

Transfer of care

There is interest from stakeholders and workshop attendees to understand patient experience related to transfer of care both into and out of small hospitals:

- Delays to transfer
- Quality of communication about the transfer
 - Between the transferring and the receiving hospital
 - Between staff and patient
 - Between staff and family/carer of patient
- Quality of patient handover
- Any difficulties experienced by the patient getting home if they were transferred out of their local area to a different hospital

Aboriginal and Torres Strait Islander patients

Aboriginal and Torres Strait Islander patients were identified by a number of stakeholders and workshop attendees as a patient group that they are interested in engaging with and providing appropriate services to. They would like the questionnaire to assess:

- Whether the small and rural hospitals provide a culturally appropriate environment, such as:
 - Culturally appropriate information and material available to patients, such as posters, information sheets etc.

- Aboriginal Health Liaison Officers available for consultations with patients who would like to see them
- Whether all patients were asked on admission whether they identified as Aboriginal, Torres Strait Islander, both or neither

Access to services

The ability of patients to access the services that are appropriate to them was another theme that stakeholders and workshop attendees identified for inclusion in the questionnaire. There were a number of different dimensions to access that were identified:

- The ability to access the service over the phone to make a booking
- The ability to access specific or specialised services through their local hospital
- The ability to access their own doctor during their inpatient stay

The care environment

Finally, the fifth major theme identified from the pro forma replies and the workshop was the need for questions about the care environment, including staff. One stakeholder identified that although questions about staff are important for accessing patient experience, care will need to be taken to preserve confidentiality in results for very small hospitals, where a rating of staff performance may be a performance review of a single doctor/nurse. Aspects of the care environment identified were:

- Hand hygiene practices
- Aesthetics (a 'calming, healing' environment)
- Quality of food and hydration
- Communication from staff
- Noise at night

4. QUESTIONNAIRE DEVELOPMENT

This section summarises how the various stages of the development process were brought together - the evidence check, the patient focus groups and the stakeholder consultation and workshop.

This process involved:

- Applying parameters/rules to guide the questionnaire development
- Creating a list of potential question areas for inclusion in the questionnaire
- Consideration of other implications arising from each stage of the development
- Applying amendments arising from the Adult Admitted Patient Survey review
- Several rounds of cognitive testing
- Extensive consultation between BHI and Ipsos

Development of rules/design parameters for the questionnaire design

The design of the SRHS built on the rules and design parameters established in the development of the Adult Admitted Patient Survey (AAPS) and the Emergency Department Patient Survey (EDPS). The same planned approach – of consultation with patients and stakeholders, and review of ‘best practice’ patient surveys – was adopted. ‘Tried and tested’ questions as a design starting point, were also used where appropriate. Similarly, the design was a process of extensive discussion between BHI and Ipsos, and finalised through 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.

To align with and allow comparison with the AAPS and EDPS, the questionnaire includes the set of national core, common patient experience questions, on behalf of Patient Experience Information Development Working Group (PEIDWG). This meant that these questions could only be amended if agreed by PEIDWG, resulting in some inconsistency in relation to the design parameters outlined above.

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:

- Mode of admission
- Delays in referral
- Attitude of staff
- Responsiveness of staff
- Organisation and communication of staff
- Competency of staff and quality of treatment
- Information provision and communication with patients, and efficiency of handovers
- Privacy
- Complaints
- Pain relief
- Cleanliness and hygiene
- Food/diet
- Referral to a specialist (time and cost)
- Transfer to/from other facilities
- Discharge
- 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 G.

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.

Cognitive testing

An essential part of the development process was the undertaking of cognitive testing to ensure the validity of the questionnaire. The aim of this is to ensure that participants were able to understand and answer the questions and that they were consistently interpreted in the way intended. This stage of development was particularly valuable given the large variety in patient 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 small and rural hospital patient experiences. This was then graphically designed and tested in the second round, to ensure

that the layout of the questionnaire encouraged participation and supported successful completion of the questionnaire.

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

- A number of questions were developed to identify the pathway of care for patients attending small and rural hospitals, specifically relating to the incidence and impact of receiving hospital care in several different settings
 - A question was added to establish whether the patients' experience at the named hospital was planned, an emergency or the result of being transferred from another facility (Q1), and if, at the end of their stay, they were transferred elsewhere (Q54)
 - Questions were developed to identify whether the patient left the named hospital for tests or treatment elsewhere, the time spent elsewhere and the reason for doing so (Q46-Q48)
 - Additional questions were included to understand the range of problems relating to this transfer, and the effectiveness of medical handover between facilities (Q49 and Q50)
- A question was added to address problems patients may have in accessing medication after discharge (Q64)
- A question was designed to address the cost of accessing treatment and care, including costs related to accommodation and transport for the patient and any others accompanying them (Q69)
- Two questions were included to understand the recurrence of patients subsequently attending ED, or being readmitted, after discharge (Q79 and Q80)
- Additional answer categories (Q10) and routing (Q19) were added to address the fact that patients may not be treated by a doctor, but by other health professionals, during their stay in hospital. Similarly, other questions were changed from the AAPS version to refer to 'health professionals' rather than the 'doctor' to reflect the greater likelihood of only being treated by other health professionals and concerns that the results may identify individual doctors (Q38-Q40).

Appendix H details the development process for every individual question in the final questionnaire, 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 discussions between BHI and Ipsos SRI).

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

The final Small and Rural Hospital Survey questionnaire is included in Appendix J.