KING'S FUND CENTRE

OBTAINING

SHIRLEY McIVER

OBTAINING THE VIEWS OF OUTPATIENTS

Shirley McIver

Consumer Feedback Resource

King's Fund Centre
Quality Improvement Programme

King's Fund Centre for Health Services Development

Published by the King's Fund Centre

126 Albert Street, London NW1 7NF
Telephone: 071 267 6111

ISBN 0 903060 93 0

Distributed by Bailey Distribution Ltd

Dept KFP, Learoyd Road
Mountfield Industrial Estate
New Romney, Kent TN28 8XU

The King's Fund Centre is a health services development agency which promotes improvements in health and social care. We do this by working with people in health services, in social services, in voluntary agencies, and with the users of their services. We encourage people to try out new ideas, provide financial or practical support to new developments, and enable experiences to be shared through workshops, conferences and publications. Our aim is to ensure that good developments in health and social care are widely taken up.

The King's Fund Centre is a part of the
King Edward's Hospital Fund for London.

Contents

Appendices – Sample Questionnaires

PREFACE

This book is the second in a series aimed at helping health service providers to obtain the views of service users. The books are written for any health service staff who have this responsibility, whether nursing, medical, paramedical or managerial. The series presumes no social science background and offers a flexible approach which is very amenable to local adaptation and interpretation. The example questionnaires given here are for guidance only and can be altered for individual use. Information about non-survey methods is provided and the reader is encouraged to combine a number of methods to achieve useful information in different circumstances and with different types of service user.

What is offered here is a practical approach to obtaining the views of outpatient service users, including basic information about the process, analysis and dissemination of results, and making use of the information obtained.

The book is produced by the Consumer Feedback Resource, an information and advice service aimed at improving feedback techniques, disseminating information about current projects and examples of good practice, networking, and building up a source of data about patient views and experiences.

ACKNOWLEDGEMENTS

I would like to thank Mary Donn, formerly of Brighton Health Authority, for providing me with the publication 'A Better Deal For Outpatients' which helped me to construct three of the example questionnaires contained in the Appendix; Simon Gilby of Trent Regional Health Authority, who asked me to design the questionnaires and then piloted them as part of the region's 'Quality Standards for Outpatients' initiative; Ian McArdle of Sandwell Health Authority, who generously allowed me to include a questionnaire designed and used by him to conduct a study of those who failed to attend their outpatient appointment; and last but not least, Tessa Brooks of the King's Fund Centre, who made useful comments on drafts of the book.

1 INTRODUCTION

Health care providers face increasing pressure to obtain the views of service users in order to monitor and improve service quality. The last few years have seen a stream of publications, most notably the Griffiths Report in 1983 and the Government White Paper *Working for Patients* in 1989, which advocate the use of surveys to check that services are meeting the requirements of patients.

Documents giving guidance on the development of contracts continue this theme. For example, the NHS Chief Executive, Duncan Nichol, in the circular 'Operating Contracts', issued in February 1990, draws attention to six points which commissioners and providers will wish to take into account when developing an approach to contracting and deciding priorities for service improvements, the first of which concerns service users: 'How the views of patients can increasingly influence management and delivery of services at all levels.'

While this increased attention to the views of service users is to be applauded, health service managers face a difficult task in putting the rhetoric into practice. Firstly, it means change from an organisation which historically 'knows best' what its users need, to one in which users can participate in decisions about their care; and secondly, it involves the development of accurate and useful ways to obtain patient views.

The first aspect addresses the question of organisational change. How is a customer service oriented culture developed? There are numerous examples of initiatives working in this direction. The best of these focus on encouraging health service staff to think of ways to improve contact with service users, in which ownership of initiatives is paramount. Those whose aim is lasting change also focus on setting up a quality management system which is built upon an all-embracing philosophy about quality.

The second aspect concerns the adaptation of social science methods and market research techniques to suit the NHS culture. Until recently social research on patients was mainly conducted by academics who had their own agenda of importance and whose aims and objectives were not necessarily of interest to health service managers; or Community Health Councils, whose agenda was closer to that of managers, but who because they lacked funds or were inexperienced, frequently produced reports which were unconvincing or difficult to act upon.

Since the Griffiths Report in 1983, an increasing number of health service providers have been conducting their own investigations into patients' views and experiences, but in the absence of clear guidelines, they have met with varying success. Those who employ market researchers or consultants to do the work for them, often have difficulty using the results, while those who carry out their own work using staff or CHC members frequently make typical mistakes in survey planning, construction and analysis.

During the 1970s, the King's Fund Centre conducted and published the results of a number of surveys which bridged the gap between academic and health service oriented work. The surveys were carried out by Winifred Raphael, and the questionnaire she used was made available for health service providers to use. The reports and questionnaires have formed the basis for many surveys conducted 'in-house' since that time.

A number of changes have taken place since the 1970s: in Britain generally, concerning health trends in the population, and in NHS structure. Not only that but in recent years, health service oriented patient research has developed (eg the UWIST/HPAU 'What the Patient thinks' survey work) and clearer guidelines have emerged (eg the Department of Health funded work done by York University's Centre for Health Economics, 'The NHS and its Customers').

These changes have made it necessary to revise and update Raphael's pioneering work and to continue the development of health service oriented patient research by establishing a source of information and advice on consumer feedback. The Consumer Feedback Resource, established in June 1989, was set up for this purpose, and this book is one of a series planned with the aim of helping health service providers to obtain accurate and useful information about the views and experiences of service users.

The Outpatient Service

A hospital outpatient department appears less like a single department than an area in which a number of different services work: consultant firms, paramedics, nurses, medical records and reception staff etc. Unless these diverse services are built into a defined management structure, there is no overall co-ordination and no one has clear responsibility for making changes. Add to this the fact that in 1988–89 outpatient departments dealt with approximately 40 million patient attendances in England and Wales, at a cost of about £1.2 billion (about 12 per cent of the total expenditure on hospital services) and you have a service which must come close to being a hospital manager's nightmare!

This complexity, plus the fact that outpatient departments attract high levels of patient dissatisfaction – the 1984 report *British Social Attitudes* found that 21 per cent of the population surveyed expressed varying degrees of dissatisfaction with this part of the service compared with 7 per cent and 13 per cent with inpatient services and with GPs respectively (Jowell and Airey, 1984) – make outpatients an obvious early choice for this series of books giving advice on obtaining the views of service users.

In outpatient departments, small changes can be very effective (eg high straight-backed chairs for the elderly and arthritic, notification of delays to appointment times, clear information about where tests take place and what they are for) so that asking patients what would make their visit a more pleasant experience helps to ensure that money is spent wisely to develop a quality service.

This book examines in some detail the survey questionnaire approach to obtaining patient views. It offers example questionnaires, provides information on non-survey methods, and gives suggestions for analysis and presentation of results, as well as making use of findings.

Those who lack the time, manpower or resources to make use of this information, flexible as it is, have a cheap, easy and useful option open to them. Do not despair. On a regular basis ask a good selection of outpatient users as they leave just two questions:

1. What did you like least about your experience of outpatients today?
2. What did you like most about your experience of outpatients today?

This will provide enough suggestions to keep most departments busy for the foreseeable future in their work toward providing a quality service. A similar cheap but effective method is described by Mark Learmonth in 'Please Speak Your Mind', *The Health Service Journal*, 12 July 1990, p. 1035. As the Outpatient Services Manager for York District Hospital, he sent out 193 letters requesting comments and received 120 replies. The cost was less than £100 but the information obtained helped him to 'understand more about people's perceptions of things such as doctors' attitudes, the atmosphere of the outpatient department and our car parking problems.'

Those who are a little more ambitious and can set aside resources, should, with the help of this book, quickly move towards a patient oriented outpatient service.

This will provide [illegible]
basis for the [illegible]
quality services [illegible]
described by Maxwell [illegible]
The Health Service [illegible]
Outpatient services [illegible]
and 1990 [illegible]
The [illegible]
him to understand [illegible]
such as clinics [illegible]
departments and [illegible]

[illegible]

2 BACKGROUND

The service which is probably used by the greatest number of new patients every year and which is likely to be the first hospital contact point for many people, is the outpatient department. As such, it is both complex and high profile, setting a real challenge to managers who want to ensure a good quality service.

It is not surprising therefore to find that users of outpatient departments have been surveyed widely. A study carried out by the Centre for Health Economics, University of York, in 1988 (Carr-Hill, McIver and Dixon, 1989) found that outpatient questionnaires formed the third largest category of survey, after inpatients and maternity. The study also established that most questionnaires used were designed for self-completion by patients, and also that although there were many kinds of questionnaires, they tended to be of three main types:

- short and single issue (such as waiting times)
- short, general evaluations of conditions, covering areas such as waiting area and reception, examination by doctor, amenities, visits to other departments and general opinions in not much detail
- much longer and more detailed questionnaires with up to 50 questions, asking all the above but in more detail and likely to include questions on travel and patients' experience of the admissions/referral system.

Of these three types, they found that the most widely used, although much adapted, questionnaire was in the second category and was produced by Winifred Raphael of the King's Fund, in 1977.

Measured in terms of frequency of use, the Raphael questionnaire is a success, but its value as a tool for obtaining the views of service users has never been assessed. It seems likely that it has been copied because it provides health service managers with a starting point. In addition it covers a number of aspects of the outpatient service in one fairly short and simple questionnaire, which is more attractive to the service manager seeking a quick overview of patient opinion, than either one dealing with only a single aspect of service delivery (such as waiting environment) or a long questionnaire which is complex and time consuming to analyse.

Now that service managers are being put under increasing pressure to obtain the views of service users, it is time to assess the usefulness of the Raphael questionnaire and to ask whether, although availability, coverage and ease of use are attractive features, these are more important than other factors, such as amount of detail or relevance to the service user? Is the Raphael questionnaire the best instrument for obtaining the views of outpatients or has it been superseded by better questionnaires or better methods? By taking Raphael's questionnaire as a valuable starting point and attempting to analyse its strengths and weaknesses, it may be possible to design an approach or combination of approaches more suited to the 1990s.

The aim here is to take Raphael's outpatient questionnaire and assess its value by comparing it both with other questionnaires and with other ways of obtaining information from service users, as well as to suggest a number of short questionnaires and non-survey methods as alternatives offering a flexible approach to producing information which is both usable and accurate. Three of these questionnaires have been constructed by the author from an outpatient checklist designed by Brighton Health Authority as part of their 'A Better Deal for Outpatients' work. The questionnaires have been piloted by Trent Regional Health Authority and form part of their 'Quality Standards for Outpatient Services' initiative. The fourth questionnaire has been designed by Ian McArdle of Sandwell Health Authority and used on a number of occasions to find out why people failed to attend an outpatient clinic appointment.

The Raphael Outpatient Questionnaire

The King's Fund published *Being an Outpatient* by Winifred Raphael and Jean Mandeville in March 1977. It presented the findings of a survey conducted in nine hospitals between 1974 and 1976. The self-completion questionnaire used was included as Appendix A with permission given for reproduction. It consisted of a total of 19 questions under each of six headings: Waiting Areas; Amenities; Examination by Doctor; General Opinion on Outpatient Department; and Additional Comments.

Advantages of the Raphael Questionnaire

The questionnaire has a number of advantages.

- ★ It is well laid out, making it easy for service users to complete.
- ★ Most of the questions have simple yes/no answers which facilitate analysis.
- ★ There is space for comments, and those answering 'no' to a particular question are encouraged to add explanations and suggestions, allowing users to go into more detail if they so wish. This provides valuable information about the kinds of improvements that users want.
- ★ It covers a number of different aspects of the outpatient service, making it possible for managers to obtain views on different aspects in one survey.

Given that Raphael also provided easy to follow instructions on how to go about conducting the survey, including the number of people to sample, how to distribute the questionnaires and how to write the report and follow it up, it is not surprising that her study and questionnaire have proved so popular.

Limitations of the Raphael Questionnaire

The Raphael questionnaire also has a number of limitations:

1 Constructing the Agenda

The questions appear to have been set by service providers rather than users. Raphael does not mention having carried out any exploratory work to find out which subject areas and issues users considered to be important. Given that only a few questions are asked, each question becomes extremely important and the number of questions devoted to each topic should reflect its level of priority to the patient. This suggests that Amenities and Waiting Areas (eight questions) are more crucial topics than others, such as provision of information (two questions). More recent research indicates that this is not the case.

2 Superficiality

The questionnaire covers a wide range of topics with very few questions. This limits the amount of detail that can be gathered on any one topic. For example, the question 'Had you time to ask all that you wanted to?' reflects only the time dimension of gathering information. A person could answer 'yes' to this and still not have *understood* the answers to the questions they asked. They *might* write this in the comments box, but perhaps they would feel stupid if they did? Additional questions reflecting different aspects of obtaining satisfactory information would provide more detail and show which aspects of a topic were satisfactory and which less so.

The questionnaire also includes a general question about overall satisfaction with the visit and it is doubtful whether this will elicit any useful information at all. Unless patients are actually asked what made the visit 'very satisfactory' or 'unsatisfactory' for them, they are not likely to be specific. The space for these comments is there, but patients anxious to leave may not take the time to explain, particularly if it is seen as additional to the 'real' question.

In common with all self-completion questionnaires, the Raphael questionnaire is also limited because it is not accessible to all people and because it is usually part of a one-way process. That is:

3 Selectivity

A number of people are unable to complete the questionnaire: those who cannot read English, or who are illiterate; those suffering from dyslexia; those who are blind or partially sighted; those who are unable to use their hands; and those suspicious of, or confused by, forms and questionnaires. This is an important limitation, because if categories of customer are being missed, their needs and views will remain unknown.

4 Lack of User Participation

The survey method is usually a one-way process in which user views are collected and no information about the results of the survey or any changes made are fed back to them. This can perpetuate the often already existing technical approach which treats users as 'objects' (in this case of survey research) rather than people. Users are not involved in exploring issues, seeking solutions to problems or making decisions about service provision – processes which treat them as human beings.

Overcoming the Limitations of the Raphael Questionnaire

Raphael's questionnaire provides a useful foundation to build upon. By keeping the good features of her questionnaire and trying to overcome the limitations, improvements can be made to the process of collecting patients' views.

The limitations described may be overcome in the following ways.

1 Constructing the Agenda

Issues considered important by service providers may not be those which are of most concern to service users. The service users' agenda can be discovered by conducting unstructured or semi-structured interviews before designing a questionnaire. A small number (15–20) of as wide a variety of service users as possible should be interviewed by someone experienced in the art (eg psychologists, social scientists or counsellors). During these interviews in which the experiences of service users are explored, areas of service provision which users consider to be important can be identified and investigated. These priority areas can then be reflected in the questions asked, and in addition, the questions can also be constructed to reflect the language users find familiar.

2 Superficiality

A short questionnaire which covers a wide range of topics is not able to go into detail on any one topic. The amount of detail needed will depend upon whether the aim of the survey is to *explore* or *monitor* patients' views. Where the views of service users are unknown, it is best to use a sensitive method such as interviews, critical incident technique or discussion groups, rather than a structured questionnaire, so that users can 'tell it like it is'. If this type of exploration of views has already taken place and the issues and areas of concern considered important by users are already known, progress on improving service quality to meet users' needs more closely can be monitored using a questionnaire.

Short questionnaires are preferable to long ones because they are less time consuming for the patient to complete, and they are easier to analyse. Yet although the questionnaire is going to be used for monitoring, it should be designed to collect sufficient detail to enable managers to find out *in what way* a particular aspect of service provision is not meeting patients' needs. This means that a questionnaire will have to be both short and specific; that is, it will be best to construct a number of short questionnaires covering specific topics, such as access to clinic or department, quality of information provided, or waiting environment.

These short questionnaires can be used in a number of different ways: *simultaneously*, to provide a 'snapshot' of user views on different aspects of the service; *alone*, to monitor a particular aspect of service delivery which is causing concern; *consecutively*, as part of a rolling programme of service monitoring; *together with other methods*, to explore a particular aspect of service delivery from a number of different angles. Short, standard questionnaires for monitoring different aspects of service delivery provide a flexible and useful tool.

3 Selectivity

Self-completion questionnaires are not always the best way to obtain information. It is important to be flexible and to use questionnaires together with other approaches and methods. If the elderly, children, black and minority groups, those suffering from a mental illness, or with learning difficulties, or those having a physical disability, make up a large proportion of those using the service, an alternative method should also be adopted in order to obtain their views. The use of a patient advocate or liaison officer, semi-structured interviews, observation, a discussion group, an advisory forum, or a combination of these approaches could prove an effective means of obtaining feedback.

4 Lack of User Participation

People should be treated as human beings and not as objects or stages in a process. It is human nature to want to be involved in decision making processes where the outcome will affect our life. There are two ways to overcome this limitation. The first is to ensure that if the survey method is used, service users (and staff) are informed about results, recommendations and possible future action. This can be accomplished in many ways, from short, easy to read, and interestingly presented details about the survey displayed on notice boards in areas where service users wait, through press and radio reports, to public meetings and displays at local fairs and similar events.

The second way is to use methods which encourage more participation, such as discussion groups and advisory forums. Apart from the value to the service user, these can help service providers think issues through and develop solutions to problems.

3 THE WAY FORWARD

A crucial issue for those seeking to obtain the views of service users is that of developing a way to obtain information which is both *accurate* and *useful*. That is, information which represents the issues that concern the majority of users and also their views on these issues; and information which answers the questions asked by service providers in a way which enables them to improve the services offered.

Service managers want to be able to identify existing areas of poor quality service and also obtain an early warning of future problem areas. This will demand a balance between exploration and monitoring of user views. This balance will probably differ between service areas and perhaps also between health authorities.

As far as outpatient departments are concerned, some exploratory work has already been carried out and a considerable amount of information already exists about the experience of users and their agenda of importance.

A particularly useful example is that of the work undertaken by North West Thames Regional Health Authority in conjunction with the Industrial Training Research Unit. Using an in-depth interviewing method called critical incident technique (see p. 29), researchers collected data from 572 patients in A & E and outpatient departments (North West Thames Regional Health Authority & Industrial Training Research Unit, 1986). In this way the researchers were able to identify six aspects which are of importance to service users:

- ★ Understanding the system
- ★ Access to information
- ★ Continuity in the pace of events
- ★ Personalised attention
- ★ Friendliness and efficiency
- ★ Consistency.

Other studies bear out the importance of these areas and so any questionnaires constructed should incorporate questions which examine these issues. Some health authorities are already focusing on many of these areas of patient concern. For example, one important aspect of Trent Region's Personal Service Initiative is to encourage district health authorities to improve the quality of personalised attention that service users receive. Other health authorities have concentrated on improving access to information and on providing a better flow of events by changing the appointment system (eg Brighton Health Authority).

In order to monitor these important aspects of service delivery in outpatient departments using short questionnaires, it may be helpful to split the service into a number of sections. For example: pre-appointment; arrival and wait; consultation; and post consultation. It should then be possible to examine each section of the outpatient service, covering the issues users consider to be important.

A useful way to tackle this is to return to Raphael's questionnaire and use the sections that she identified: access; waiting times; waiting environment and amenities; satisfaction with treatment by staff; and support services.

These sections divide the outpatient service in an appropriate way, but each section is too complex to be part of a single questionnaire – each needs to be examined separately.

Modifications to the Raphael Questionnaire

The short length, section headings and simple yes/no answer format are valuable aspects of the Raphael questionnaire but four modifications are needed in order to overcome the limitations discussed.

- The use of a separate questionnaire for each section, in order to preserve the short length but increase the amount of information obtained.
- Questions which cover the service users' agenda.
- The use of methods other than the self-completion questionnaire where these are more appropriate.
- Feedback about the results of the survey to users, and/or the use of methods which encourage more participation from users, such as discussion groups and advisory forums.

Each of the sections will now be examined in more detail, bearing in mind the proposed modifications, and an approach to obtaining information from a user perspective will be described.

Access

A self-completion questionnaire could be used to collect information about convenience of appointment times, travel, knowledge of where to go, signposting etc. This could be tied to a study of 'did not attends' for a full picture of ease of access, where a postal questionnaire, telephone survey or home interviews could be used to gather information about why people did not keep their appointment. Failure to keep an outpatient appointment is common and apart from disrupting the clinic appointment system, it may affect the patients' health, as studies have found (see, for example, R Andrews et al, 'Understanding Non-attendance in Outpatient Paediatric Clinics' in *Archives of Disease in Childhood,* Vol. 65, 1990, pp. 192–195).

An example of a self-completion questionnaire on 'Getting to the Clinic' can be found in Appendix 1. This has been piloted by Trent Regional Health Authority. An example of a questionnaire used successfully by Sandwell Health Authority to investigate those who did not attend their appointment can also be found in Appendix 1.

Where large numbers of people who may not be able to fill in a questionnaire attend the outpatient department, or fail to attend, an alternative method should also be used to capture their experiences. These methods will be described in a later section.

Waiting Times

This is an extremely difficult topic to investigate using a questionnaire because a number of questions have to be asked at various times throughout the appointment, or at the end, when a patient may well have forgotten the details: What time did you arrive? What time were you seen by the receptionist? What time was your appointment? What time were you seen by the consultant? At the blood test/X ray/pharmacy department? etc.

Questions asking people about their opinion regarding the waiting time (eg Were you satisfied with ... ?) are inappropriate because it is obvious that everyone wants to wait for as short a time as possible and the aim must be to decrease waiting time to one which is locally feasible.

Questions about whether information about waiting time and delays was provided, on the other hand, are very important and can be asked as part of a questionnaire about information provision.

Perhaps one of the best methods to use to examine outpatient waiting times is a time recording system of some kind, a card system which has the time of different events filled in by staff at each location. A number of health authorities are now working on this approach, particularly in Trent Region. For example, managers in the outpatient department of the Pilgrim Hospital (South Lincolnshire Health Authority) are devising a tracking system using what they describe as a statistical process control approach, which starts with an analysis of waiting times for three client group users of the X ray service (inpatient, outpatient and A & E). Their aim is to define a reasonable working time, given emergencies, and then to monitor waiting times to match against the standard.

The Maternity Clinic at Kings Mill Hospital (Central Nottingham Health Authority) have already experimented with a card system. They added a time card to the medical records of 250 attenders. The information collected was analysed and the results made available to the consultants involved, who found it useful. It contradicted the taken for granted assumption that most people arrived very early for their appointment, and the block booking system was stopped. The patient tracking initiative, originally part of Trent Region's Midwifery Manpower Planning Project in 1989, is now an established procedure and one which the clinic hopes to employ every six months as a monitoring tool forming part of their service contract.

After considerable work on improving the outpatient service, Brighton Health Authority have found that a more streamlined recording system works for them. The time of the first and last appointment is recorded, plus the *actual* time the first and last person is seen. This is carried out for all clinics over a period of a month, approximately once every three months.

Waiting Environment

Although traditionally an area covered by self-completion questionnaires, the North West Thames Regional Health Authority study showed that issues to do with physical environment were irritants rather than crucial areas of concern for customers.

This does not mean that the standard of the waiting area can be ignored, but it seems reasonable to assume that most of the requirements are obvious and can be checked by an observer: availability of refreshments, magazines, lavatory facilities; chair arrangements, etc. Quality of facilities is a different issue (eg cleanliness, standard of food, relevance of magazines) but although a self-completion questionnaire could be constructed around these issues, a better approach might be for management to use a detailed checklist to examine environmental standards.

Some requirements may not be quite so obvious, such as the friendliness of the environment to those with a disability, the elderly, children and non-English speakers. The checklist could include questions related to these requirements and it may be necessary to use an advisory group or liaison officer to establish the needs of these different categories of user in the first instance.

Satisfaction with Treatment by Staff

Many self-completion questionnaires ask whether staff are friendly or helpful but these questions are often too vague and unspecific to gather useful information. According to many studies, the way that health service staff communicate with patients and whether they provide sufficient information are crucial areas of concern to service users, and questionnaires must reflect this importance.

Both interview and questionnaire surveys have repeatedly highlighted poor communication between staff and patients as a major area of patient dissatisfaction. As early as 1964, Ann Cartwright devoted four chapters of her book *Human Relations and Hospital Care* to communication between patients and staff, at which time she found 'an unsatisfactory state of affairs'.

Later studies reinforced this view. For example, King's Fund research by S Steele and D Morton in 1978 found that 63.4 per cent of 302 patients interviewed in three hospitals expressed some level of dissatisfaction with the way staff communicated with them. Similarly, Janet Gregory in *Patient Attitudes to the Hospital Service* (1978) found that 37 per cent of outpatients wanted more information about their progress and nearly 1 in 7 of all patients she interviewed had been given what they felt was insufficient information about their progress.

More recent research indicates that the picture has not changed much. When reviewing CHC and health authority inpatient surveys, Jones, Leneman and Maclean (1987) found that dissatisfaction with communication featured in many of them.

The research conducted by North West Thames Regional Health Authority in 1985, based on interviews using critical incident technique with 572 patients in outpatient and A & E departments, found staff/patient interaction and communication to be extremely important to patients: 29 per cent of all incidents reported dealt with customer/staff interaction and staff behaviour; 46 per cent of all the good practices described the interpersonal skills of staff.

There are a number of aspects of staff/patient communication which need to be tackled. These are:

Content of Information

- ★ **Procedures** – eg how the system works, what the process will be, where events will take place, what will happen next.
- ★ **Treatment** – eg what is wrong, what tests and tablets are for, what treatment choices exist, what they must do.

The Way Information is Conveyed

- ★ **Accessibility** – is it understandable, conveyed using the best medium, at the most appropriate time etc.
- ★ **Attitude** – the way staff convey the information, whether in a friendly, non-threatening, understanding manner or not.

The task of investigating and improving staff/patient communication is perhaps the most complex one to tackle, but from the service users' point of view it is also probably the most important. It will involve finding out where poor communication exists, through questionnaires and either a liaison officer or an advisory group to help gather information from some categories of customer, such as the elderly, children and non-English speakers.

Changes, such as improvements in the type and quantity of information supplied to patients, and staff training in communicating with patients, will need to be followed by further investigation to evaluate the effectiveness of these changes. An excellent staff checklist covering all the practices outpatient users consider important, including a long list of those involving good communication, can be found in the North West Thames booklet *Managing Customer Relations: The Elements of Good Practice in A & E and Outpatient Departments* (North West Thames Regional Health Authority & Industrial Training Research Unit, 1986).

An example of a short self-completion questionnaire dealing with 'Quality of Information' given to patients can be found at Appendix 2. This has been piloted by Trent Regional Health Authority.

Support Services

A visit to an outpatient department frequently involves tests or treatment at another location: X ray, physiotherapy, EEG, blood analysis etc. This experience forms an important part of the visit and it is one which can be examined using a self-completion questionnaire, although much useful information could also be gained through 'participant observation'. That is, by following individual customers throughout their visits to other departments and making notes of the experience.

An example of a self-completion questionnaire entitled 'Diagnostic Tests' which has been piloted by Trent Regional Health Authority can be found at Appendix 3. Instead of using a standard questionnaire for all test sites and departments, individual services may want to develop their own. For example an EEG technician in the EEG Department at Severalls Hospital, North East Essex Health Authority, is conducting a survey of patients as part of a degree by independent study. The Speech Therapy Department of St Albans' City Hospital is also involved in a survey of former and current patients, carers and staff.

4 CONDUCTING THE SURVEY

Detailed information about conducting a survey can be found in texts referenced at the end, but the following questions occur regularly and so answers might prove useful to those planning a survey.

What is the correct sample size ?

The crucial aspect of a sample is the number and nature of non-respondents. A small number of respondents which includes all people visiting a clinic over a typical period is better than a large number where dozens of people have been missed. It is difficult to make categorical statements about numbers, but at least three methods can be used, depending upon clinic size.

A Aim to get every attender to take part over a short period of time (eg two days).

B Aim for a particular number of respondents and keep going until the figure is reached (eg 30 per clinic).

C Choose every nth person until the target figure has been reached.

In all cases the number of non-respondents (refusals, unable to take part, too ill etc) must be noted.

The method adopted will depend upon clinic arrangements. For example, if different clinics are run from one outpatient department on different days, the process will take a number of days and it may be necessary to aim for a set number of people from each clinic to make up a suitable final number. On the other hand, if one particular clinic has a very large and varied number of attenders, it may be necessary to try and obtain responses from every attender over a two day period.

Sample size is only a major worry if the survey is a 'one-off' and is thought of as producing the final judgement on a service. Surveys should be part of a rolling programme to obtain user views and the results taken along with other information and used as a basis for making changes and improving service quality. If the same questionnaire is used regularly (eg once every four months), the survey can build up a useful body of information about the experience of service users.

Is it necessary to ask for details of a person's age, sex, housing and employment status etc ?

This will depend on the reason the information is being collected. Are these likely to be relevant categories? Will they alter a person's views and opinions? Even though they are not giving their name, many people feel reluctant to complete 'personal detail' sections of questionnaires. If *they* consider the questions to be irrelevant to their views then they will leave them unanswered.

For the *monitoring* of service quality, these socio-economic questions seem largely unnecessary and so have not been included on the example questionnaires in the appendices (except for the one devised by Sandwell Health Authority). It would be a simple matter to add age and sex, if these are considered important.

The *exploration* of issues is a different matter and where questionnaires or interviews are used for this purpose, then at least some socio-economic questions are probably relevant and should be included.

When is the right time to hand out the questionnaire ?

The most relevant time for most service users to fill in the questionnaire is as they are about to leave, but unfortunately this is also the time when most people least want to do so. It may also be difficult if seating is limited and the clinic busy, so that there is nowhere for patients to sit and complete the questionnaire.

Generally, if patients are given the questionnaire as they arrive, they can complete some sections while waiting and the rest as they proceed through their visit. It helps to have someone to remind them to complete it, or hand it in, as they leave, but a self-addressed prepaid envelope will also be useful for those who really cannot finish it.

Each department will have to work out the most practical solution to suit local circumstances but if a number of semi-independent staff (or CHC members) can be recruited to collect questionnaires and help anyone having difficulties filling them in, it will improve the response rate.

Should clinics where large numbers of people attend regularly be included ?

It will probably be necessary to separate out clinics with regular attenders from those with mixed or few regular attenders because the different circumstances may make different questions appropriate. Many surveys omit outpatient clinics with regular attendance, such as psychiatric departments and obstetrics (eg Raphael's survey), but it is obviously important to elicit the views of these users in some way.

What alternatives are there to the self-completion questionnaire survey ?

Self-completion questionnaires, even those which feature specific questions and include plenty of space for comments, will not collect as much complex information as less structured methods. More comments will be encouraged if the questionnaire is actually treated as a structured interview schedule, because in an interactive situation people are more likely to make comments than if they are completing the questionnaire themselves.

If at all possible, it is best to have one or two interviewers handing out the self-completion questionnaires so that they can use the form to interview those who cannot complete it for any reason. This procedure will work in fairly crowded waiting areas, as long as the respondents do not have hearing difficulties, making it necessary for the interviewer to speak loudly.

Sometimes it is necessary to collect complex information: in situations where little is known about the views and experiences of service users, or to answer questions which involve a number of different issues. In these instances it is better to use non-survey techniques. Some of the main techniques available are as follows.

Interviews

These can be *semi-structured,* where some of the questions are set and some left open; or *open,* where no questions are formally set. The term 'open' means that topics are brought up for general discussion and these topics can be determined by the person who is being interviewed.

There is also *critical incident technique* (CIT), which is directed at collecting information about what happened to a person and about what they liked or disliked about their experiences. The method has been very fully described and its use illustrated in the North West Thames Regional Health Authority/Industrial Training Research Unit publication *Managing Customer Relations* (1986).

CIT seems to be gaining support as a method and has recently been used by a number of health organisations, including the Scottish Health Service Management Development Group, Mid-Glamorgan Health Authority and Oxfordshire Health Authority. Michael Pryce-Jones, the management consultant used by Oxford Regional Health Authority to develop use of the technique in the region, has written a number of articles on the subject (see 'Not How Many But Why: A Qualitative Approach to Customer Relations', *Health Service Management,* December 1988, pp. 175–177, and 'Satisfactory Practice', *The Health Service Journal,* 30 November 1989, pp. 1464–5).

Discussion Groups

Many people are not articulate and so not able to respond well in interviews. They may feel more relaxed, however, amongst people who have gone through similar experiences. Also, as part of a group they may find their experiences given shape and form in the words of others, and so be better able to express their own views.

The method is not yet widely used within health authorities, but it is regularly used by market research companies, where it is commonly known as the group depth interview, focus group or focused group discussion. In the USA, where it has been used extensively since the 1950s, the number of group interview projects commissioned each year far exceeds the number of surveys (Goldman and McDonald, 1987).

In Britain, the discussion group has been used extensively by Social and Community Planning Research (SCPR), an organisation which also runs training workshops on research methods, including the discussion group. The SCPR publication *Keeping in Touch with the Talking: The Community Care Needs of People with a Mental Illness* (1988) gives details of use of this method during a research study carried out on behalf of the Birmingham Community Care Special Action Project.

One or two health authorities are beginning to use the method. For example, East Birmingham Hospital ran a discussion group session with patients attending a pain clinic in the outpatient department in July 1990. Members of East Birmingham and Solihull Community Health Councils ran the discussion, which was organised by the outpatient services manager.

Advisory Groups

This term covers a wide range of groups of different kinds set up to advise health professionals on the views of users. They may have an all professional membership, an all consumer membership, or be made up of a mixture of professionals and consumers. The role of these groups can vary from gathering and presenting the views of users, to discussing and making decisions about service provision.

For example, the Outpatient Department at Harold Wood Hospital, Barking, Havering and Brentwood Health Authority, has a Patients Users Group which has been running since January 1989. This is an advisory group comprising service users and representatives from voluntary and self-help organisations who meet once a month on average. Their role is to provide professionals with information about the views and needs of service users. This has included suggestions about improvements to the waiting environment, the provision of patient information, and a review of the internal and external signposting.

At Springfield Hospital, Wandsworth Health Authority, on the other hand, the Patients Council comprises a group of service users who see one of their main aims as that of a self-help and patient support group. The Council, which was established in October 1988, advises the Mental Health Unit Management Group on service development and improvement as well. It has been instrumental in obtaining a number of changes: for example, weekend opening of patients' recreation areas; the upgrading, cleaning and signposting of public toilets in the hospital; the drafting of a patient's handbook; and the organisation of a staff/patient seminar about quality of life at ward level.

Patient Advocate/Liaison Officer

Strictly speaking, the job of patient advocate is to work on behalf of the client rather than merely convey his or her views, but the term can be applied loosely to any worker who acts as a 'go between' representing the views of the patient to the service provider, and vice versa.

This type of worker is particularly necessary where the patient group is disadvantaged, in a particularly powerless position, or where the patients' language and culture of birth is not English, but it can improve the chances of obtaining accurate information about patients' views in most cases.

There are a number of patient advocates working with ethnic minorities. For example, Hackney Multi-Ethnic Women's Health Project, which is based at City and Hackney Community Health

Council, employs a number of advocates whose main role is to interpret and promote the views of black and minority women who are experiencing difficulties obtaining and using health services, but details of individual cases also provide information about problems experienced more generally by women using the services.

The main alternatives to the self-completion questionnaire have been described, although the list is not comprehensive (see McIver, 1991, for further details). The important point is that no method is perfect for every situation and each one has limitations. The best approach is to use a combination of methods to overcome the weaknesses of each, and to suit the particular circumstance.

For outpatient departments, it would seem sensible to use a self-completion questionnaire to collect information on straightforward issues that require regular monitoring. New or complex issues will necessitate the use of an alternative method, as will the process of collecting information from black and minority groups. At times it may be useful to supplement the information collected using questionnaires, by observation or the use of a liaison officer.

A different combination of methods will suit other service areas. For example, the Princess Grace Hospital, owned by AMI Healthcare, uses three methods to obtain information from inpatients: (1) each patient is interviewed prior to their discharge; (2) a self-completion questionnaire and freepost envelope is left in every room; (3) the quality assurance officer is available and will meet any patient or relative on request.

In many service areas, avenues for collecting information from service users will already be established and will only need to be formalised and made more systematic.

5 DATA COLLECTION AND ANALYSIS

The process of collecting data is very straightforward when a structured questionnaire is used because it is clear that responses to questions should be recorded, but it is not so obvious what should be recorded during a discussion group or advisory forum.

The aim should be to try and record as much as possible, particularly in the early stages when it is not clear what will emerge as important and what will turn out to be a passing comment. When one person is managing a session and it involves considerable dialogue, it is usually best to tape record the proceedings. This will enable the group facilitator to relax a little and follow the conversation, encouraging it to proceed along useful lines.

Alternatively, if two people are involved, one can pay attention to the structure of the discussion and manage proceedings while the other notes particularly interesting points, and jots down indicators of who is speaking, to help when the tape is transcribed. This is a useful back up to the tape, which can become inaudible when two or three people speak at once or someone moves noisily at a critical moment.

Complete transcription of dialogue from tape to paper is *extremely* time consuming: probably 4–5 hours for a one and a half hour discussion. It is very useful to have complete transcripts, but if *what* is being said is more important that *how, when* or *by whom* it is said, then it is possible to obtain a satisfactory amount of data by listening to the tape and summarising what it recorded. A number of typical sentences and sections of dialogue can be transcribed as verbatim quotes for illustration purposes.

The aim of data collection is to record as much information as possible as it occurs and not to rely on memory. The memory records information in a biased and unsystematic way and although you might believe it will retain the important points, it is not always possible to know initially what is and is not important because this may emerge later as issues recur.

Having said this, it is still important to note down your own perceptions of what seems important, as these can be useful in making sense of the material when you start analysis; but these observations should be kept separate.

Collation of Data

Before the data can be analysed, it needs to be broken down and collated into manageable chunks. Again, this is a relatively easy process where questionnaires are concerned because the chunks can be the different sections of the questionnaire, but what is a manageable chunk if a discussion group has been used to collect information? Is it one session or a series of sessions taken together and collated under different topics? What about the data produced by a liaison officer?

Usually, with discussion groups, it is a series of discussion groups tackling a particular issue which is equivalent to the survey, and the issues that emerge around the questions asked are the 'responses' or 'chunks'.

An advisory group meeting is slightly different and it is probably best to try and collate information after each session of this kind of group meeting. Whether a full report is written after each meeting will depend upon the number of points raised, but given the amount of time needed to produce a full report it is likely that information from a number of sessions will need to be recorded, collated and analysed, before a report is prepared.

A liaison officer should make notes during and immediately after each meeting with service users and others who give information about service use. He/she should collate the information frequently (probably once a week) and collect it into a report at regular intervals (perhaps every three months).

The collation process involves relating the information gathered to information which has been collated by others doing similar kinds of work, in order to set it in context and aid in the understanding and location of important points.

Analysis of Data

Analysis is the process of making sense of the data collected. Many people find it useful to draw up tables categorising the data, or construct grids, flow charts or maps with it. This enables them to examine the relationship between different aspects of the information collected.

Certainly it is worth following a step by step procedure, such as:

- ★ summarising the material into a series of points
- ★ looking for recurring points and noting how many times they occur and with what qualifications or differences, if any
- ★ aggregating the information by noting the most frequently occurring points and any other points which seem to be of particular importance, bearing in mind the context.

At this stage it is sometimes worth writing the 'findings' up and offering them to the original discussion group or forum for comments, particularly if some points are unclear. These 'findings' will then go towards the production of a draft report.

6 REPORT WRITING AND DISSEMINATION

It is not enough to collect user views – little can be done if the information is not written up and made available to those who can act on the results. At the outset sufficient time should be allowed for preparation of the report and plans made for dissemination. The initial report should be as comprehensive as possible, even though the eventual aim might be to produce a series of short briefing papers. It is useful to include the following sections.

I **Introduction** – Background to the study, sometimes including a brief literature review of the area.

II **Method** – A descriptive section on how the information was collected, number of people interviewed or otherwise asked for information, number of people who were asked to take part but refused etc.

III **Results** – The information collected, often using direct quotes to illustrate points.

IV **Discussion and Conclusion** – Any qualifications or additional information obtained from other sources which might reflect upon the results is discussed before conclusions are drawn up.

V **Recommendations** – These are suggestions for changes to be made to improve service quality, based on the information collected during the study. They are sometimes attached to the report at the beginning rather than the end.

VI **Appendices** – These should include any questionnaires or interview schedules used, and also some assessment of the exercise itself. Were there problems with the method used? How were these overcome, if at all? Should changes in the procedure be made in future? This section will be valuable to others who are about to attempt something similar, as well as being part of a learning process for those involved.

A report with recommendations for action is dependent on management commitment to make changes following feedback information. It may not be possible for changes to take place immediately, but dissemination of the main findings and recommendations is still important, because both staff and service users who have heard about or been involved in the feedback exercise will feel demoralised if nothing more is heard about it. Why did they bother to help in the first place if no one seems to have taken any notice of what they said?

There are a number of important audiences for the user feedback report, although each will require a different type of presentation. For example:

Health service managers, professionals and staff
Possible media: Reports and presentations to working groups etc; seminars involving different groups of staff with an interest or involvement in the service concerned; in-house journal; staff training courses and events.

Informed lay people – such as health authority members, CHC members, those involved in voluntary groups, pressure groups, black and minority groups and community organisations
Possible media: Reports and presentations; fact sheets.

Service users who took part in the survey/exercise – or whose relatives and friends might have done so
Possible media: Display boards at relevant sites, such as waiting areas of service departments, wards, day rooms, entrance lobbies etc.

Other service users and the local community in general
Possible media: Local newspaper, radio, health newspaper, open days etc.

Other health authorities and customer feedback officers
Possible media: The King's Fund Centre Consumer Feedback Resource; Health Service Journal, professional journals etc.

7 INFORMING THE MANAGEMENT AGENDA

The outpatient department is one in which a number of services operate: consultant firms, paramedics carrying out diagnostic tests, receptionists, medical records staff and nurses. Any attempt to change one element of the department is bound to have repercussions on other parts and so co-ordinated action is vital.

Given that the aim of surveys and other activities to obtain patients' views is to change services to improve quality for the service user, some change is inevitable and so a co-ordinated approach should be planned at the outset. In any case, the survey activity itself will require co-ordination.

The research carried out by the Centre for Health Economics (Carr-Hill, McIver and Dixon, 1989) showed that health service managers often have difficulty making use of information obtained during 'one-off' surveys. The aim of the more flexible approach suggested here is to improve 'usability'. Managers can concentrate on different issues at different times if they wish, or can tackle them simultaneously if this is more convenient. They can explore some issues, while monitoring others, and so on. This flexibility also increases the complexity of the process of obtaining consumer views, however, so that co-ordination and the existence of a system for building the information into the management process becomes extremely important.

Many outpatient departments already have service managers and/or working groups, and they would seem to be in an ideal position to co-ordinate feedback activities. An outpatient working group functions best if it is multi-disciplinary, having representation from the different parts of the outpatient department. Its purpose should be to examine the outpatient department as a whole, looking at the way the different parts fit together, and a good example of how this might work based upon a project which took place in the Oxford Region is described by D M P Jones in 'An Approach to Tackling Administrative Problems in Hospital Out-Patients Departments', *Hospital and Health Services Review*, July 1986, pp. 152–154. Jones writes, his group 'is virtually a corporate supervisor of the department whose authority is accepted and which can make operational adjustments far more easily than any individual could.'

Such a group might also be responsible for receiving and discussing the regular reports from the different feedback activities, as well as for deciding what else needed to be done and how changes could be made to improve services.

An outpatient service manager would be in a position to take responsibility for the day to day running of feedback activities, such as making sure that staff know when they are taking place and what they should do to help.

An ideal management system might include:

MANAGEMENT STRUCTURE	DOCUMENTS INDICATING PROGRESS	ACTION
OUTPATIENT WORKING GROUP (comprising eg section heads, consultants, outpatient manager, CHC member, black and minority worker and/or member of community group and perhaps UGM)	Outpatient policy statement relating to provider contract specifications, including customer relations issues Outpatient standards document for each service area involved, including standards relating to customer quality of care	Devise action plan indicating when and how standards are to be monitored, when areas are to be explored and reviewed Match results of feedback activities against standards Arrange dissemination of results: public relations, staff and customer communication Identify staff training needs
OUTPATIENT MANAGER/ SECTION HEADS	Action plan; IPR	Co-ordinate and implement action plan; oversee feedback and standard checking activities
SERVICE MANAGERS	Standards documents; IPR	Construct, review and monitor standards; obtain informal feedback from customers

The outpatient department presents a real challenge to health service managers who are keen to develop a customer oriented service, but unlike other service areas the problem lies less in the difficult task of finding out details about the patients' agenda of importance than in monitoring patients' experiences and making appropriate changes to the organisation and running of the department.

These changes may be large scale developments such as the setting up of a multi-disciplinary working party to tackle the knock-on effect of different activities, but small scale changes such as the instigation of a system to notify patients of delays to their appointments can also improve the service from the users' perspective. The important point is to start making changes.

Hopefully this book has given an indication of the foundation upon which customer oriented changes in outpatient departments should rest. The three main elements of this foundation are that it should:

- ★ Be based upon the commitment of a *multi-disciplinary* working group of some kind.
- ★ Involve the *systematic and regular* monitoring of user views and experiences.
- ★ Take a *flexible* approach to getting information from the service user – one which suits the customer and is likely to collect the information required.

USEFUL ADDRESSES

CASPE Ltd

14 Palace Court
Bayswater
London W2 4HT

Tel: 071 229 8739

Piloting a monitoring system using short questionnaires scanned by an optical reader which speeds up the process of analysis.

Social and Community Planning Research (SCPR)

35 Northampton Square
London EC1V 0AX

Tel: 071 250 1866

A good source of information on qualitative and quantitative research techniques.

Scottish Health Feedback

69 Gilmore Place
Edinburgh EH3 9NU

Tel: 031 228 2167

Information, advice and help with survey work.

Cultural Partnerships Ltd

90 De Beauvoir Road
London N1

Tel: 071 254 8217

Help with alternative (non-survey) ways of getting the views of service users.

Nottingham Advocacy Group Ltd and Nottingham Patients Council Support Group

Kilbourn Street
Nottingham NG3 1BQ

Tel: 0602 484111

Information about setting up patients' councils and advocacy groups for mental health services.

REFERENCES

Carr-Hill R, McIver S, Dixon P. *The NHS and its Customers.* University of York: Centre for Health Economics, 1989.

Goldman Alfred E, McDonald Susan Schwartz. *The Group Depth Interview: Principles and Practice.* New Jersey: Prentice-Hall, 1987.

Jones L, Leneman L, Maclean U. *Consumer Feedback for the NHS: A Literature Review.* King Edward's Hospital Fund for London, 1987.

Jowell R, Airey C eds. *British Social Attitudes: The 1984 Report.* London: Gower, 1984.

McIver S. *An Introduction to Obtaining the Views of Users of Health Services.* London: King's Fund Centre for Health Services Development, 1991.

North West Thames Regional Health Authority & Industrial Training Research Unit. *Managing Customer Relations: The Elements of Good Practice in A & E and Outpatient Departments.* 1986.

Other Useful References

Dixon P, Carr-Hill R A. 'Customer Feedback Surveys – An Introduction to Survey Methods'. In: Booklet 2 of Carr-Hill R, McIver S, Dixon P. *The NHS and its Customers.* University of York: Centre for Health Economics, 1989.

(A cheap and concise basic guide to survey construction)

International Hospital Federation. *And What Would They Know About It?* The International Hospital Federation, 2 St. Andrew's Place, London NW1 4LB, 1988.

(A concise, clearly written basic guide to getting patients' views and using them as part of a quality assurance programme)

Luck M, Lawrence B, Pocock B, Reilly K. *Consumer and Market Research in Health Care.* London: Chapman & Hall, 1988.

(An expensive – about £23 – but fairly comprehensive basic guide to developing a market research programme, based on survey work carried out in South Birmingham Health Authority)

Cartwright A. *Health Surveys in Practice and in Potential.* King Edward's Hospital Fund for London, 1983. (Paperback reprint, 1988.)

(A very detailed review, a good source of references on the use of surveys in other areas of health)

National Consumer Council. *Consulting Consumers in the NHS: A Guideline Study.* 20 Grosvenor Gardens, London SW1 0DH, 1990.

(An excellent source of guidelines for finding out the views of service users, particularly those having communication difficulties)

OPCS, Val Mason. *Women's Experience of Maternity Care – A Survey Manual.* HMSO, 1989.

(A good guide to constructing a postal questionnaire)

Walker Robert ed. *Applied Qualitative Research.* London: Gower, 1985.

(A good practical introduction, with examples and information about analysis, to methods such as depth interviewing, group interviewing, participant observation and projective techniques)

Winn Liz, Quick Allison. *User Friendly Services.* London: King's Fund Centre for Health Services Development, 1989.

(Guidelines, with examples, for managers of community health services)

Winn Liz ed. *Power to the People.* London: King's Fund Centre for Health Services Development, 1990.

(Guidelines for developing consumer responsive services in health and social care – examples of consumer involvement through self-advocacy, user groups, consultation panels etc)

Quality Assessment – The Service to Outpatients. An instrument for providing a measure of the quality of service provided for outpatients. Quality Promotion Department, Southampton and South West Hampshire Health Authority, Western Hospital, Oakley Road, Millbrook, Southampton SO9 4WQ. Price £6.50.

APPENDICES

The following example questionnaires may be used freely by health service providers, but in return the Consumer Feedback Resource is keen to build up a picture of how and where they are being used and so would welcome details about the use of these questionnaires and also the development of non-survey methods in outpatient departments. If you find this book useful, please let us know! Thank you.

Appendix 1A – Getting to the Clinic

Clinic Reference:
Date:

OUT-PATIENT QUESTIONNAIRE

Getting to the Clinic

The ____________ is keen to tailor services to suit as closely as possible the needs of patients and so it is conducting surveys on different aspects of the services provided.

This survey is about your experiences of making an appointment and travelling to the Out-Patient Department.

We would be grateful if you would answer the following questions by ticking the appropriate box and writing comments where you would like to provide us with further information. Your name is not required and the information you supply will remain anonymous.

Please help us to improve the service we provide you with.

Thank you.

TICK YES OR NO

1. Is this your first visit as a patient to the Out-Patient Department?

Yes ☐

No ☐

---

2. Were you given an appointment for a time convenient to you?

Yes ☐

No ☐

Comments ________________________________

---

3. Were you informed about how you could change the appointment time if you needed to?

Yes ☐

No ☐

Comments ________________________________

Appendix 1A – Getting to the Clinic (continued)

4. Were you given a telephone number to ring should you have a query?

Yes ☐

No ☐

Comments ____________________

5. Were you given directions to the hospital and information on car parking, public transport etc., on your first visit to the Out-Patient Department?

Yes ☐

No ☐

Comments ____________________

6. How did you travel here today?

By car ☐

By walking ☐

By train ☐

By ambulance ☐

Other ☐

7. Did you have any problems getting here? (For example did you have difficulty parking, catching a bus etc).

Yes ☐

No ☐

If yes, please describe ____________________

Appendix 1A – Getting to the Clinic (continued)

8. Did you have any difficulty finding this clinic?

Yes ☐

No ☐

If yes, please describe ____________________

____

9. Do you have any other comments you would like to make about your experience of attending this Out-Patient Department?

____

PLEASE HAND YOUR COMPLETED QUESTIONNAIRE TO A MEMBER OF STAFF BEFORE YOU LEAVE THE CLINIC.

Appendix 1B – Outpatient Non-attendance

Clinic Reference:
Date:

QUESTIONNAIRE ABOUT APPOINTMENT NON-ATTENDANCE

Please tick the relevant box for each question or, where appropriate, use the space provided for your answer.

1. How old are you?

1-15 ☐ 16-64 ☐ 65-74 ☐ 75+ ☐

2. To act as a check on our records, please tick the appropriate box:

a) I confirm I did not keep my appointment ☐

b) I did keep my appointment ☐

c) The appointment was rearranged for ☐

________________ (date)

If you ticked (b) or (c) you need not complete the rest of the questionnaire but please write your name on the top and return it to me. For those who ticked (a) please answer the following questions.

3. Was it: Your first appointment at this clinic? ☐

One of series of out-patient appointments ☐

A follow-up appointment after a stay in hospital ☐

4. Do you feel you received adequate advance notice of your appointment?

Yes ☐ No ☐

5. How much notice was this?

Up to one week ☐

Up to one month ☐

Between one and three months ☐

Between three and six months ☐

Appendix 1B – Outpatient Non-attendance (continued)

Between six months and twelve months ☐

More than twelve months ☐

6. Did you receive the appointment?

By post ☐

In person at the clinic ☐

7. Was the reason for your non-attendance at the out-patient clinic because you:-

Received treatment for your condition your elsewhere ☐

Felt too ill to attend ☐

Forgot the appointment ☐

Was on holiday ☐

The condition cleared up ☐

Had problems with transport to the hospital ☐

(If so, was this public/private/ambulance) ☐

Had difficulty in obtaining time off from work ☐

Had problems in arranging for someone to look after children or other dependents at home ☐

8. Was there another reason, not covered above, why you did not attend? If so, please give details:-

____

____

____

9. Did you try to contact the appointments office to tell them you could not come?

Yes ☐ No ☐

10 If yes to question 9, were you

successful ☐ unsuccessful ☐

Appendix 1B – Outpatient Non-attendance (continued)

11. If unsuccessful would you tell us what the problems were

____

____

12. If you telephoned when did you ring

The day of the appointment ☐

The day before the appointment ☐

Less than a week before the appointment ☐

More than a week before the appointment ☐

13. What steps do you think we could take to make it easier for people to

Attend appointments ______________________________

____

____

Cancel appointments ______________________________

____

____

14. Have you any comments you wish to make about the out-patient hospital and its organisation?

____

____

____

____

15. Would you be prepared to meet me in confidence to discuss your answers more fully?

Yes ☐ No ☐

Appendix 1B – Outpatient Non-attendance (continued)

16. If your answer to question 15 was yes, please write below your name and address and a telephone number if you have one:

Name ______________________________

Address ______________________________

____

____

Telephone Number ______________________________

Thank you for your co-operation in completing this questionnaire. Please use the pre-paid envelope for its return.

Appendix 2 – Quality of Information

Clinic Reference:
Date:

OUT-PATIENT QUESTIONNAIRE

Quality of Information

The ____________ is keen to tailor services to suit as closely as possible the needs of patients and so it is conducting surveys on different aspects of the services provided.

This survey is about the information given during your visit. In particular we want to find out if you were satisfied with the information provided by staff here.

We would be grateful if you would answer the attached questions by ticking the appropriate box and writing comments where you would like to provide us with further information. Your name is not required and the information you supply will remain anonymous.

Some questions ask about your consultation with the doctor. We would be grateful if you would spare a few minutes after you have seen the doctor to answer these before you leave the clinic.

Please help us to improve the information we provide you with.

Thank you.

TICK YES OR NO

1. Is this your first visit as a patient to the Clinic/Outpatients?

Yes ☐

No ☐

---

2. When you arrived here at the clinic today, was it obvious who you should report to?

Yes ☐

No ☐

Comments ____________________________________

---

3. Were you addressed by staff at all times in a friendly and courteous manner?

Yes ☐

No ☐

Comments ____________________________________

Appendix 2 – Quality of Information (continued)

4. Were you clear about who you should report to?

Yes ☐

No ☐

Comments ____________________

5. Were you addressed by staff at all times in a friendly and courteous manner?

Yes ☐

No ☐

Comments ____________________

6. When the test/procedure was conducted, did anyone explain to you what was happening?

Yes ☐

No ☐

Comments ____________________

7. Were your questions answered in a way you could understand?

Yes ☐

No ☐

Comments ____________________

8. Would you have like further information about your tests?

Yes ☐

No ☐

Comments ____________________

Appendix 2 – Quality of Information (continued)

9. Did you see the doctor you were expecting to see?

Yes ☐

No ☐

I was not expecting to see any doctor in particular ☐

Comments ______________________________

---

10. If there were other people present at your consultation, did the doctor explain who they were?

Yes ☐

No ☐

There was no one else present ☐

Comments ______________________________

---

11. Was the consultation interrupted by people coming in or by the telephone ringing?

Yes ☐

No ☐

Comments ______________________________

---

12. Did the doctor answer your questions in a way you could understand?

Yes ☐

No ☐

I did not have any questions ☐

Comments ______________________________

Appendix 2 – Quality of Information (continued)

13. When you left the consultation were you clear about what was going to happen next? (for example - whether you were going to have another appointment, were being referred back to your GP, or were being admitted).

Yes ☐

No ☐

Comments ____________________

---

14. If you thought of more questions after you left the consultation did you know who to ask for further information?

Yes ☐

No ☐

I did not have any questions ☐

Comments ____________________

---

15. Do you have any other comments you would like to make about your experience of either waiting to see the doctor or seeing the doctor?

Please place your completed questionnaire in the box provided or with a member of staff.

Appendix 3 – Diagnostic Tests

Clinic Reference:
Date:

OUT-PATIENT QUESTIONNAIRE

Diagnostic Tests

The ______________ is keen to tailor services to suit as closely as possible the needs of patients and so it is conducting surveys on different aspects of the services provided.

This survey is about your experiences of going for the various tests that might have been required as part of your visit.

We would be grateful if you would answer the attached questions by ticking the appropriate box and writing comments where you would like to provide us with further information. Your name is not required and the information you supply will remain anonymous.

Please help us to improve the service we provide you with and make your visit as convenient as possible.

Thank you.

TICK YES OR NO

The questions below refer to your visit to the _________ Department.

1. Were you given clear directions of where to go?

Yes ☐
No ☐

---

2. Did you find your way easily?

Yes ☐
No ☐

Comments ____

---

3. When you arrived at the right place did you know what to do?

Yes ☐
No ☐

Comments ____

Appendix 3 – Diagnostic Tests (continued)

4. Did all staff address you by your name when they spoke to you?

Yes ☐

No ☐

Comments ____________________

---

5. Was it clear to you who each member of staff you saw was (for example, did they introduce themselves, did they wear a name badge)?

Yes ☐

No ☐

Comments ____________________

---

6. If you had to wait more than 30 minutes after your appointment time, were you told the reason why and how much longer you might have to wait?

Yes ☐

No ☐

I waited less than 30 minutes ☐

Comments ____________________

---

7. Did you know who to ask if you had any queries?

Yes ☐

No ☐

Comments ____________________

---

8. Was that person available or easy to contact during the time you were there?

Yes ☐

No ☐

Comments ____________________

Appendix 3 – Diagnostic Tests (continued)

9. When you left the test service, were you clear about where you were going next?

Yes ☐

No ☐

Comments ______________________________

---

10. Do you have any other comments you would like to make about this part of your care today?

PLEASE PLACE YOUR COMPLETED QUESTIONNAIRE IN THE BOX IN THE MAIN WAITING AREA OR HAND IT TO A MEMBER OF STAFF BEFORE YOU LEAVE.

Printed by The College Hill Press Ltd (TU), London and Worthing

This series offers a practical guide to enable care professionals to decide from ***whom*** they want to get feedback, ***why*** they want to do it, ***how*** they want to do it, and ***in what way*** they can ensure that the service improvements occur as a result.

£6.50

ISBN 0-903060-93-0

9 780903 060936